

Assessment in Action

*Improving Community Health
Assessment Practice*

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Community Health Assessment In Action Report

Executive Summary

Background

In 2002, the U.S. Centers for Disease Control and Prevention (CDC) awarded funding to the Washington State Department of Health (DOH) to improve the quality and effectiveness of community health assessment practice among Local Health Jurisdictions (LHJs) across the state. To implement the CDC grant, the LHJs and DOH formed the Assessment in Action (AIA) partnership. A Steering Committee comprising LHJ and DOH staff representatives provides leadership for implementation of the partnership. An Advisory Committee made up of a broad-based group of individuals from the Washington Health Foundation, Turning Point, United Way, the University of Washington, health and human services staff from Oregon, the LHJs, and DOH provide input on Steering Committee processes and products.

As a first step toward developing strategies to improve assessment practice, the AIA Steering Committee contracted with Clegg & Associates to conduct this intensive, participatory review of community health assessment practice among the state's LHJs. The purpose of the review was to create a body of knowledge from which the partnership could develop a set of practice improvement strategies to pursue during the remaining four years of the CDC grant. The project builds on the recently completed *Standards for Public Health in Washington State: Baseline Evaluation Report* (which documents the extent to which LHJs and DOH are meeting assessment standards) by identifying successful approaches to community health assessment, analyzing the factors that contribute to this success, and developing strategies to enable other LHJs and DOH to learn from these approaches to improve their own results.

Defining Community Health Assessment

To ensure a clear focus for this practice improvement initiative, the AIA Steering Committee created the following working definition for community health assessment practice: "Collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve public health." Such practice entails:

- Carrying out the assessment activities necessary to meet the Standards for Public Health related to understanding health issues
- Building a local constituency invested in examining and addressing community public health issues

- Developing and distributing accurate, timely, and user-friendly information regarding the health status of the local population
- Facilitating strategic decision-making regarding the response to assessment findings

To better identify the role assessment plays in achieving changes in local health status, the Steering Committee and Clegg & Associates developed a logic model. This logic model articulates the program theory underlying community health assessment:

ACTIVITY		SHORT-TERM OUTCOMES		LONGER-TERM OUTCOMES		GOAL
Conducting community health assessment activities	⇒	Changes in attitudes, awareness, and knowledge/skills regarding the use of assessment data in decision-making	⇒	Changes in programs, policies, and resources	⇒	Improved community health status

Research Methodology

In order to capture how LHJs are implementing community health assessment, Clegg & Associates conducted one-hour telephone interviews with 34 of the 35 LHJs. Participants were asked to describe their current assessment capacity, what changes had resulted from assessment activities, what resources were essential, what obstacles they have encountered, and how important they believe the assessment function is to the LHJ achieving its goals. In addition, Clegg & Associates interviewed nine key informants identified by the AIA Steering Committee as having important perspectives on community health assessment, including several DOH staff. The AIA Steering Committee used the information learned in the telephone interviews to select six LHJs for Clegg & Associates to visit. The purpose of the site visits was to gather more in-depth information about practice methods that are working in specific LHJs and to identify the factors that contribute to success.

The LHJs selected for site visits were Island County Health Department, Jefferson County Health and Human Services, Kitsap County Health District, Kittitas County Health Department, Spokane Regional Health District, and Thurston County Public Health and Social Services Department. These six sites comprised one large LHJ, three medium-sized LHJs, and two small LHJs. The sites included two health districts, two county health departments, and two county health and human services departments. Four of the LHJs visited were in Western Washington, one was in Central Washington, and one in Eastern Washington.

At each site visit, Clegg & Associates met with the LHJ director and assessment staff and held focus groups with internal and external stakeholders. External stakeholders included

Board of Health members, individuals serving on LHJ community advisory/mobilization groups, other community partners, hospital administrators, and others. Internal stakeholders included health officers and LHJ program staff.

In order to enhance the transfer of knowledge between the AIA partnership and the LHJs, Clegg & Associates conducted a search of current research pertaining to effective knowledge dissemination and utilization processes. Recommendations for improving the quality and effectiveness of community health assessment practice across the system were then developed in conjunction with the AIA Steering Committee and Advisory Committee.

Findings

KEY FINDINGS FROM THE TELEPHONE INTERVIEWS

- Every LHJ performs some assessment activities; not every LHJ (nor everyone at each LHJ) thinks of these activities as community health assessment
- Most LHJs see the value of community health assessment even if they believe they lack the capacity to sustain effective assessment practice. (Nearly 75 percent of all LHJs consider assessment to be very important or “mission critical.”)
- For LHJs that do not consider assessment very important, the main reason cited is a lack of discretionary funding
- Nearly all LHJs have lost funding and assessment capacity since the mid-1990s
- Every LHJ said they need more money to conduct community health assessment. Other frequently-cited important resources included staff capacity, DOH support, technology and data, and community partners
- Obstacles to community health assessment include a lack of time and money, resistance to change, competing priorities, and a lack of understanding of what assessment is and what it can do, and a lack of a clear vision from DOH
- “Champions” are important in starting and growing assessment capacity
- LHJs reported a number of positive impacts as a result of assessment, including:
 - Increased resources
 - Increased effectiveness
 - Better decision-making
 - Increased ability to act proactively
 - Increased visibility
 - Improved services
 - Increased collaboration and cooperation
 - Improved community perception of LHJ
 - Increased awareness of public health issues
 - Decreased influence of politics on LHJ priorities

- Most LHJs use some of their Local Capacity Development Funds to support assessment. Other funding sources include grants, contracts, county general funds, and local funds. A few LHJs do not fund assessment.
- Community health assessment is most likely to be sustained when LHJs see assessment as an investment that leads to increased resources or improves their ability to do more with fewer resources and when communities come to view LHJs as vital partners because of their assessment capacity

KEY FINDINGS FROM THE SIX LHJ SITE VISITS

There is no one *right* way to conduct community health assessment. Each of the LHJs that participated in a site visit implements community health assessment in a way that is tailored to its own community. This customization contributes greatly to the success these LHJs are achieving in educating and mobilizing their communities to address a broad range of public health issues.

At the same time, there are a number of key similarities that emerge from these individual sites. The following characteristics common to the six LHJs appear to be critical in making community health assessment practice an effective ingredient in achieving the LHJs' goals:

- Leadership and vision are essential
 - LHJ directors have an expansive vision of public health and the role of the community in achieving it
 - Directors view assessment as a core function
 - The health officer is engaged in the assessment function
 - The Board of Health makes an important contribution
- The community is a powerful partner in achieving health goals
 - Five of the six LHJs visited have a community-based stakeholder group of some kind. These groups are invested in public health issues and bring an additional, and separate, voice to local public health issues. The size, structure, and composition of these groups vary – the key is that the LHJ has an active voice in addition to its own.
- Dedicated staffing (and staff) make a big difference
 - Assessment is a dedicated staff function
 - Assessment staff have direct access to the LHJ director
 - Staff conducting assessment have passion for it
 - Staff development and training are available

- LHJs committed to assessment find a way to make it happen
 - Paying for assessment takes creativity and commitment
 - Directors who value assessment find a way to pay for it
 - LHJs move beyond traditional funding streams to pay for assessment
 - Assessment weathers budget reductions
- Access to key supports is critical
 - Access to useful, timely data
 - Ability to take advantage of peer learning opportunities
 - Technological expertise, in such areas as statistical analysis and epidemiology, as well as enhancements, such as GIS capability and web design/posting

KEY FINDINGS REGARDING KNOWLEDGE DISSEMINATION AND UTILIZATION

- Organizations need to have the adaptive capacity (i.e., internal and external factors in place to support change) to incorporate new knowledge into existing practice
- Effective knowledge dissemination requires a link between the information being disseminated; the needs, beliefs, experiences, and skills of the intended audience; and the dissemination approach or strategy
- Research points to considerations or factors disseminators of information can take into account to increase the effectiveness of knowledge dissemination efforts, e.g., demonstrating the benefits of the information/knowledge when translated to practice, providing ongoing support and personal intervention, focusing on a problem-solving approach
- “Messengers” are critical – they need to be trusted, knowledgeable opinion leaders

Recommendations

Clegg & Associates developed recommendations for the AIA Steering Committee that include asset-building work at multiple levels. These recommendations provide the foundation for the AIA partnership to assist the LHJs and DOH in creating a statewide network of communities using assessment to plan actions for public health improvement.

The following recommendations describe *what* needs to take place to improve community health assessment practice throughout the state. The subsequent stage in this process, the development of a four-year work plan, will detail *how* the AIA partnership will translate these recommendations into specific strategies to improve the capacity of LHJs and DOH to successfully conduct community health assessment practice throughout the state. This work plan will be completed prior to the beginning of the second year of the CDC grant in October 2003.

RECOMMENDATION #1

Create a stronger system at the LHJ and DOH levels to support implementation of community health assessment practice

The four-year implementation phase for the AIA grant offers an opportunity to make significant gains in strengthening the assets required at the LHJ and DOH levels for statewide community health assessment capacity. The following asset-building recommendations are not easy to accomplish – they require vision, commitment, financial resources, a willingness to change, and strong coordination between the LHJs and DOH.

- Develop critical assets at the LHJ level, e.g., leadership, assessment capacity, Board of Health support, community partners
- Build complementary assets at the DOH level, e.g., articulation of community health assessment purposes, demonstration of data-driven decision-making, organizational and technical support for LHJs
- Forge a shared LHJ/DOH vision for the role of community health assessment in achieving the public health standards and public health goals
- Improve DOH integration of the funding and reporting of assessment activities taking place in categorical programs with broader DOH and LHJ community health assessment efforts
- Enhance the type and amount of assistance DOH provides to help LHJs build their capacity to conduct community health assessment, e.g., providing/analyzing data, organizing trainings and workshops, providing mentoring opportunities

RECOMMENDATION #2

Help LHJs build the community health assessment capacity necessary to achieve the Public Health Standards related to “Understanding Health Issues”

The 35 LHJs are at different stages of development in their use of community health assessment as a tool in achieving the public health standards and strengthening community health. This recommendation offers a customized approach that each LHJ can employ to begin improving its community health assessment practice, regardless of where it is on the development continuum. As part of the implementation process, the AIA partnership could create a self-evaluation tool to help each LHJ identify which group it fits best with and the strategies from which it would most benefit.

· Group One

The LHJs in this group currently focus primarily on the implementation of categorical public health programs, e.g., Maternal and Child Health, HIV/AIDS, drinking water quality, and are not performing many community health assessment

activities. They may not have a capacity-building process underway that will lead to achievement of the *Understanding Health Issues* standards.

The practice improvement focus for LHJs in Group One is on establishing the value of community health assessment as a means to achieving the public health standards and the LHJ's goals. A secondary focus is on the different methods for developing organizational capacity to conduct a sustainable community health assessment effort. Strategies include assisting LHJs in selecting a community health assessment project to implement and providing technical assistance to complete it, assistance in implementing and learning how to use Vista software, and organizing peer mentoring among LHJ directors.

- **Group Two**

These LHJs have added broader issue areas, e.g., domestic violence, to their public health focus. They see the value of community health assessment to better understand health issues but do not see a way to go beyond some limited efforts due to a lack of financial resources. As a result, they may conduct discrete community health assessment activities but do not have an ongoing mechanism for involving stakeholders in setting priorities and planning public health improvements.

The practice improvement focus for Group Two is on developing the organizational capacity, both in terms of finances and expertise, to develop and conduct a sustainable community health assessment effort. Strategies include investigating implementing regional health assessment capacity, providing skills training on forming and facilitating collaborative processes, and providing peer mentoring opportunities.

- **Group Three**

The LHJs in Group Three are engaged in a variety of community-based health-improvement initiatives around issues like violence prevention. They view community health assessment as a critical function in achieving the public health standards and attaining their LHJ and community goals. They have dedicated some amount of internal staff or consultant time to community health assessment and are active in seeking out additional assessment projects. These LHJs may have a strong community-based assessment focus and are interested in developing a stronger internal use of data to inform program design, decisions, and policies.

Strategies for Group Three include providing a tool LHJs can use to determine the appropriate next steps in improving their community health assessment practice, convening statewide peer learning workshops, and offering skills training in teaching community agencies and LHJ program staff how to collect and analyze data.

RECOMMENDATION #3

Make community health assessment more useful to personal health and environmental health programs

Community health assessment practice is not contributing adequately to the achievement of personal health and environmental health program goals within LHJs. There are numerous benefits assessment could bring to these program areas, but this contribution has not yet been realized. LHJ leadership and staff involved in assessment have an opportunity to share the benefits of data-driven program and policy decision-making with these program areas. The willingness of assessment staff to reach out and encourage the participation of the staff in these program areas is critical in making this happen. Specific strategies for implementing this recommendation include:

- Develop a vision for the role of community health and environmental health assessment in achieving the personal and environmental health-related standards and program goals. One implementation strategy would be to convene a leadership-level work group from DOH and LHJs to create a vision and identify individuals who can champion the importance of community health assessment.
- Offer training opportunities, e.g., customized leadership development training, community mobilization training
- Support professional development opportunities by ensuring that training on community health assessment is available at state-level personal health and environmental health conferences

Introduction

Organizations charged with protecting the public's health are turning with greater frequency to the community as a partner in fulfilling this responsibility. The ability to enlist the energy and expertise of local residents to take on critical programmatic and financial sustainability issues is becoming an essential asset for every local health jurisdiction (LHJ). It has become clear to many LHJs that they cannot significantly impact the health status of their local communities without involving local residents and organizations in the effort.

Many LHJs are using community health assessment as a means to mobilize the community in achieving these changes in community health. This practice includes collecting, analyzing, and sharing data about the health status of the community, facilitating community mobilization efforts to address identified health issues, and advocating for policy and programmatic changes that will engender sustainable changes in health status. Through community health assessment, public health agencies and community partners work together to improve the quality of life for local residents.

Project Focus

In 2002, the U.S. Centers for Disease Control and Prevention (CDC) awarded funding to the Washington State Department of Health (DOH) to improve the quality and effectiveness of community health assessment practice among LHJs across the state. The recently completed *Standards for Public Health in Washington State: Baseline Evaluation Report* (which documents the extent to which LHJs and DOH are meeting assessment standards) indicated that the local health departments and health districts in Washington are at different stages of development in their implementation of community health assessment practice.

The goal of the project is to identify successful approaches to community health assessment, analyze the factors that contribute to this success, and develop strategies to enable other LHJs and DOH to learn from these approaches to improve their own results. The opportunities for LHJs to learn from their peers and enhance the quality and effectiveness of their community health assessment practice are far-reaching.

In order to implement the CDC grant, the LHJs and DOH formed the Assessment in Action (AIA) partnership. A Steering Committee comprising LHJ and DOH staff representatives provides leadership for implementation of the partnership. An Advisory Committee, made up of a broad-based group of individuals from the Washington Health Foundation, Turning Point, United Way, the University of Washington, health and human services staff from Oregon, the LHJs, and DOH, provides input on Steering Committee processes and products.

As a first step toward developing strategies to improve assessment practice, the AIA Steering Committee contracted with Clegg & Associates (CAA) to conduct this intensive, participatory review of community health assessment practice among the state's LHJs. The purpose of the review was to create a body of knowledge from which the partnership could

develop a set of practice improvement strategies to pursue during the remaining four years of the CDC grant. The scope for review includes the following elements:

- Describe the capacity of LHJs throughout the state to conduct community health assessment
- Identify the strengths and gaps in the current state-local system for assessment
- Identify the outcomes (in terms of policy/program change, etc.) that LHJ assessments have driven
- Identify interesting approaches to effective assessment practice (meaning assessments that led to some discernable action)
- Identify factors that have contributed to (or hindered) the sustainability of assessment capacity in LHJs
- Research the current findings regarding the most effective methods for disseminating knowledge and encouraging the utilization of innovative practices
- Articulate the changes needed to improve and enhance the effectiveness of community health assessment practice across the state

COMMUNITY HEALTH ASSESSMENT PRACTICE

Community health assessment comprises a variety of activities at the LHJ and DOH levels. A diverse array of individuals within the LHJs conduct these activities, including assessment staff, program staff, agency leadership, and members of boards of health. In addition, local public and non-profit organizations and community stakeholders play a vital role in implementing an effective community health assessment practice. DOH also has an important contribution to make: the provision of epidemiological data, technical assistance in using the data, training, and leadership around practice improvement efforts.

To ensure a clear focus for this practice improvement initiative, the AIA Steering Committee created the following working definition for community health assessment practice: “Collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve public health.” Such practice entails:

- Carrying out the assessment activities necessary to meet the Standards for Public Health
 - Standard 1: Public health assessment skills and tools are in place in all public health jurisdictions and their level is continuously maintained and enhanced
 - Standard 2: Information about environmental threats and community health status is collected, analyzed, and disseminated at intervals appropriate for the community
 - Standard 3: Public health program results are evaluated to document effectiveness (a review of the assessment practice related to achievement of this standard will be carried out separately)
 - Standard 4: Health policy decisions are guided by health assessment information, with involvement of representative community members

- Standard 5: Health data is handled so that confidentiality is protected and information systems are secure (a review of the assessment practice related to achievement of this standard will be carried out separately)
- Building a local constituency invested in examining and addressing community public health issues facing the community
 - Enlist the interest, commitment, and involvement of individuals, organizations, and other health department programs in the examination of community health issues
- Developing and distributing accurate, timely, and user-friendly information regarding the health status of the local population
- Facilitating strategic decision-making regarding the response to assessment findings
 - Provide leadership to assist the health department, other government agencies, and non-profit organizations plan local strategies to address the problems and opportunities posed by assessment results
 - Create an environment that embraces evidence-based decision-making through the use of research to establish priorities and sequence implementation of strategies

It is important to note that the AIA Steering Committee specifically excluded program evaluation from this review in order to keep the focus on community health assessment.

As with many practice improvement initiatives, this review provides an opportunity to examine the inner workings of a subset of the LHJs that are using community health assessment to achieve program and policy change. This examination offers a vehicle for other LHJs who wish to learn from the sample group. In addition, it identifies the areas where DOH practice needs to improve to support community health assessment among the LHJs.

The successful implementation of community health assessment practice requires an effective partnership between DOH and the LHJs; each has roles to play and responsibilities to fulfill. The AIA partnership is working collaboratively to improve the effectiveness of these partners' efforts.

Methodology

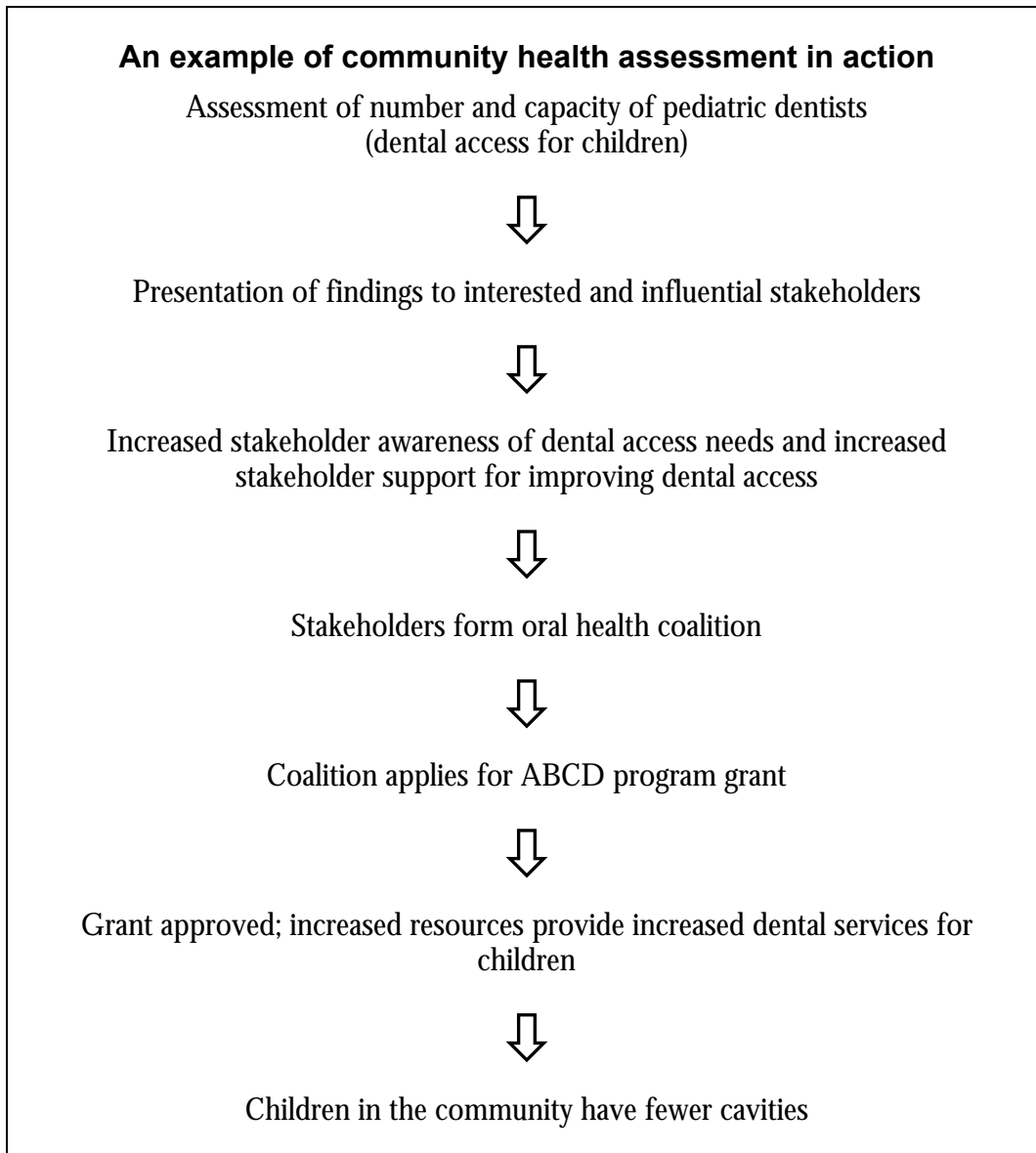
Defining Community Health Assessment

The AIA community health assessment review began with a meeting of AIA Steering Committee members and Clegg & Associates staff. A key task for this meeting was agreeing on what the term “community health assessment” means. The group defined the intent of community health assessment as collecting, analyzing, and using data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve public health. The group developed the following list of activities as typical of their efforts to involve the community in achieving short-term and long-term public health goals:

- Consulting with stakeholders
- Gathering and analyzing data
- Preparing reports
- Presenting findings
- Leading discussions on the significance of findings
- Facilitating development of strategies to respond to the data
- Providing technical assistance in using the data

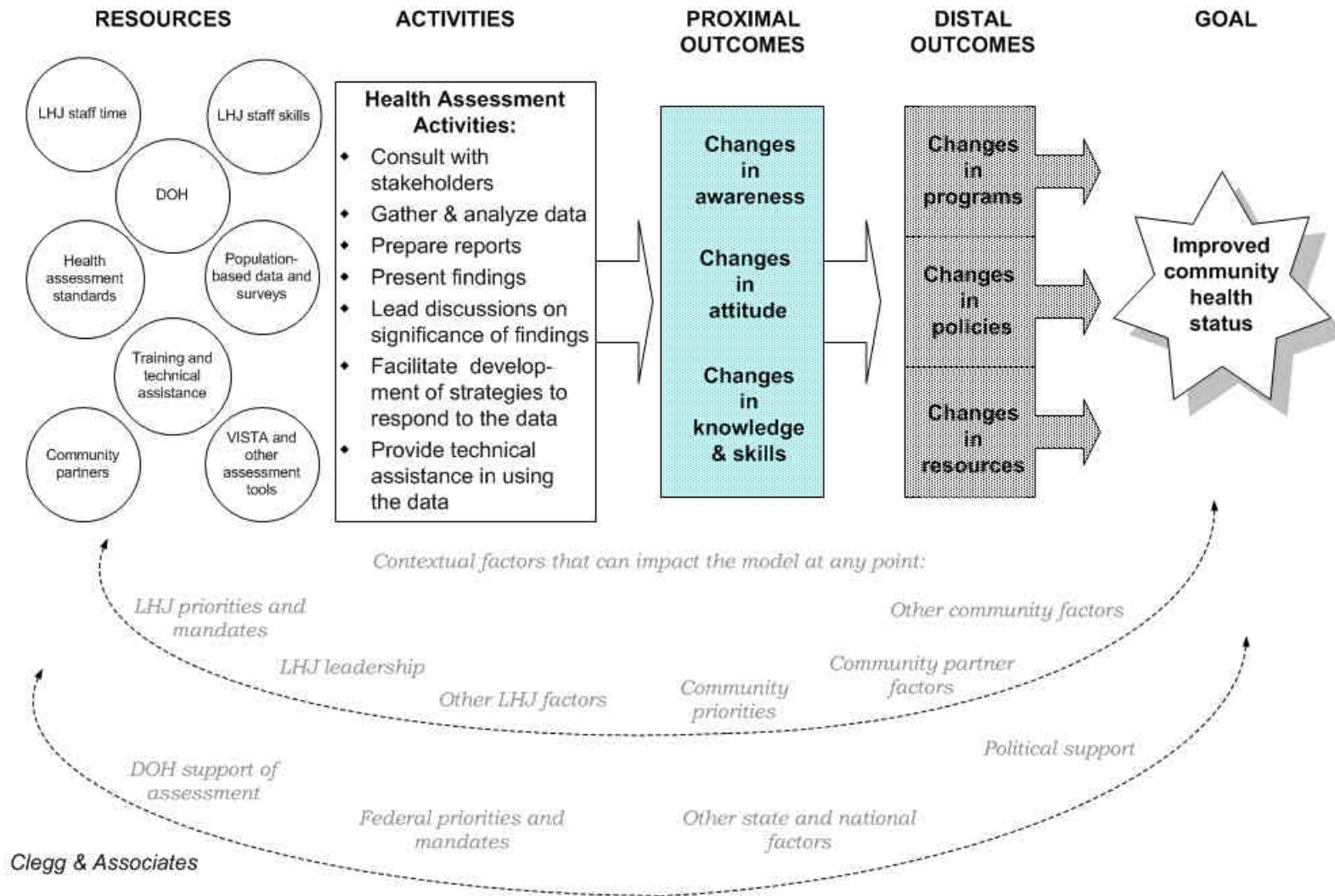
LOGIC MODEL

To better identify the role assessment plays in achieving changes in local health status, the Steering Committee and Clegg & Associates developed a logic model which depicts the following program theory underlying community health assessment. Conducting community health assessment leads to changes in attitudes, awareness, knowledge, and skills regarding the use of assessment data in decision-making. These changes lead to changes in programs, policies, and resources that ultimately result in improved community health status. (It is important to note that the assumptions and theory behind the community health assessment logic model are not evidence-based, to date.)



A logic model depicting the AIA program theory for community health assessment is shown on the following page. Having needed resources such as LHJ staff time and skills, population-based data and surveys, Vista and other assessment tools, and DOH training and technical assistance allows LHJs to undertake community health assessment activities that lead to changes in community health status. Contextual factors such as state and federal priorities and mandates can impact the model at any point and can affect the ability of LHJs to realize the results they are striving for through community health assessment.

AIA Community Health Assessment LOGIC MODEL



Telephone Interviews

The AIA logic model is a general overview of a model practice in community health assessment. In order to capture how LHJs are implementing community health assessment, Clegg & Associates conducted one-hour telephone interviews with 34 of the 35 LHJs. Clegg & Associates distributed an interview guide developed jointly with the AIA Steering Committee to LHJ directors (a copy of the interview guide is in the Appendix). Directors were asked to involve anyone they felt could best answer the interview questions. For some LHJs, the director alone answered the questions. For some, both the director and assessment staff participated, and for others, the directors delegated the interviews to assessment staff. In all, 27 directors and 29 assessment staff participated in telephone interviews.

In addition, Clegg & Associates interviewed nine key informants identified by the AIA Steering Committee as having important perspectives on community health assessment. Key informants included DOH staff and independent consultants who have worked with LHJs on community health assessment. Findings from these key informant interviews are not described separately in this report. These interviews provided primarily background and contextual information for the LHJ interviews, as well as suggestions that have been incorporated in the recommendations.

INTERVIEW QUESTIONS

LHJ interview participants were asked to describe:

- Their current assessment capacity and how it is structured and funded
- How the assessment function has evolved over time and what impacts or changes have resulted from assessment activities
- What resources are essential for assessment and what obstacles they have encountered
- Who the main constituencies for assessment are
- How important they believe the assessment function is to the LHJ achieving its goals

Key informant interview participants were asked to describe:

- Their vision of community health assessment's potential
- What roles they think it is most important for DOH and LHJs to play and what obstacles get in the way of each performing its role
- Ways in which DOH and LHJs are working well together on assessment and ways in which they are not working well together
- How the DOH/LHJ partnership could be strengthened
- How important the assessment function is to LHJs achieving their goals
- How important DOH's role in supporting community health assessment is to the DOH agency mission

The interviews were semi-structured, with each interviewee asked a common set of (mostly) open-ended questions. Interviewers used different probes to follow-up, depending on the respondent's answers. Not all interviewees were asked the same follow-up questions. Therefore, the analysis and findings do not include percentages of respondents or other directly quantitative statements. Instead, the number of responses is characterized by the following terms: one, a few, some, most, nearly all, every. Approximate numerical ranges for these terms are shown below:

- One = 1 LHJ
- A few = 2-4 LHJs
- Some = more than 4 and less than half (5-17)
- Most = more than half of the LHJs (18 – 29)
- Nearly all = 30 or more LHJs
- Every LHJ = 34 LHJs¹

Selection of LHJs for Site Visits

Clegg & Associates presented the findings from the telephone interviews to the AIA Steering Committee and facilitated the Committee's discussion and agreement on six LHJs to participate in site visits. In selecting site visit locations, the aim was to identify LHJs that would provide the most useful information for development of recommendations for improving assessment practice. "Most useful" was defined as offering the most learning benefit for other LHJs (and for the public health system as a whole) to enhance the effectiveness and impact of community health assessment work.

Site Visit Criteria

Evidence of a promising/model approach to community health assessment (i.e., an approach linked to action and impacts)

Approach to assessment appears replicable within other LHJs

Approach to assessment appears sustainable over time

LHJ is facing/overcoming common obstacles to assessment

LHJ is willing to serve as a site visit for this review

Site visit locations collectively represent the diversity of LHJs (in terms of size, structure, geographic location, etc.)

About half the LHJs met the criterion of showing evidence of a promising approach. Narrowing the list down to six LHJs was a difficult task. It came down to choosing one LHJ

¹ There are 35 LHJs; Clegg & Associates was not able to interview the Clallam County Department of Health and Human Services.

over another because it provided more diversity to the mix of sites or had elements that seemed more likely to be instructive to others.

The Committee believed that having a mix of large, medium-sized, and small LHJs was important. “Size” was defined according to budgetary, as opposed to population, measures, as follows:

- Large LHJs have an annual budget of more than \$10 million (5 of 35 LHJs or 14%)
- Medium-sized LHJs have an annual budget of between \$2 million and \$10 million (10 of 35 LHJs or 29%)
- Small LHJs have an annual budget of less than \$2 million (20 of 35 LHJs or 57%)

LHJ “structure” refers to how the LHJ is organized within its jurisdiction. The Committee believed including LHJs with various structures, e.g., health departments, health districts, would be helpful.

Based on these criteria, the Steering Committee selected the following six LHJs for site visits:

- Island County Health Department
- Jefferson County Health and Human Services
- Kitsap County Health District
- Kittitas County Health Department
- Spokane Regional Health District
- Thurston County Public Health and Social Services Department

These six sites comprise one large LHJ, three medium-sized LHJs, and two small LHJs. The sites included two health districts, two county health departments, and two county health and human services departments. Four of the LHJs visited were in Western Washington; one was in Central Washington, and one in Eastern Washington.

Site Visits

Clegg & Associates and the AIA Steering Committee developed a site visit guide. At each site visit, Clegg & Associates met with the LHJ director and assessment staff and held focus groups with internal and external stakeholders. External stakeholders included Board of Health members, individuals serving on LHJ community advisory/mobilization groups, other community partners, hospital administrators, and others. Internal stakeholders included health officers and LHJ program staff. The table on the following page summarizes site visit participants.

In order to gather the information necessary to create the community health assessment improvement strategies, the site visits focused on four areas:

- Obtaining a rich description of the sites in terms of the specific role assessment has played in achieving short- and longer-term impacts at the LHJ and broader community levels

- Identifying the factors that make assessment successful in these LHJs
- Understanding the pathways these LHJs have followed in achieving their successes
- Capturing the LHJs' insights into the strategies that could be employed to make the knowledge gleaned from the site visits transferable to other LHJs and communities

Each site participated in discussions regarding a common set of questions, as well as customized questions that addressed specific model approaches shared by that LHJ during its telephone interview. A copy of the interview guide is in the Appendix.

Sample Site Visit Questions

For Directors and Assessment Staff:

What are the most critical resources, activities, and outcomes for community health assessment in your LHJ?

How have you developed the resources you utilize in performing community health assessment?

What have you found to be the most effective strategies for engaging the community?

For External Stakeholders:

What changes are you aware of that have resulted from the department/district's efforts to understand the health of the community through data and assessment?

How did you develop your current working relationship with the department/district in regard to assessment activities, e.g., who initiated the relationship, how long has it been in existence, what challenges have you and the health department/district experienced, how have you dealt with these challenges?

Why is data important to this community for planning ways to improve the community's health?

SITE VISIT FOCUS GROUP/INTERVIEW PARTICIPANTS

	Island	Jefferson	Kitsap	Kittitas	Spokane	Thurston
Director	✓	✓	✓	✓	✓	✓
Health Officer	✓		✓		✓	✓
Assessment Staff	2	1	2	1	3	2
Other LHJ Staff	3	1	3	6	6	3
External Stakeholders (Total)	6	3	6	3	6	5

External Stakeholders by Role*	Island	Jefferson	Kitsap	Kittitas	Spokane	Thurston
Board of Health		1	2	1		1
Advisory Committee	6	2		3		
Community Agency	2	2	2	1	4	1
Hospital			1	1		1
Community member	4		1	1	2	1
DOH Staff						1

*Note: Stakeholders are listed under each role they serve; some stakeholders serve multiple roles, e.g., Advisory Committee member and Community Agency representative. Therefore, the numbers below will not necessarily add up to the total number of external stakeholders.

Knowledge Transfer Research

The AIA Steering Committee is interested not only in information *dissemination* – or the spread of information and knowledge – but also information *utilization*. In order to enhance the transfer of knowledge between the AIA partnership and the LHJs, Clegg & Associates conducted a search of current research pertaining to knowledge dissemination and utilization processes. A number of literature reviews, referenced in the Appendix, were found from various sources worldwide. The literature describes what is currently known about what effective knowledge dissemination and utilization is and the conditions that allow it to occur. The findings of this research are intended to assist in the identification and framing of AIA strategies for years two through five of the CDC grant.

Development of Recommendations

Clegg & Associates presented the findings of the site visits and the knowledge transfer research to the AIA Steering Committee and facilitated discussion of a draft set of recommendations. The recommendations are based on all the review research – telephone interviews, site visits, and knowledge transfer research. Steering Committee discussion helped to categorize and refine the recommendations.

Findings

Telephone Interview Findings

Current LHJ Capacity to Perform Community Health Assessment

Key Findings

Every LHJ performs some assessment activities; not every LHJ (nor everyone at each LHJ) thinks of these activities as community health assessment.

Most LHJs see the value of community health assessment even if they believe they lack the capacity to sustain effective assessment practice.

Program evaluation is an area where there is increasing demand for assessment, but most LHJs have little capacity in evaluation.

LHJs generally focus on the health assessment activities they believe they have the most capacity to undertake.

The definition of community health assessment (see Methodology) encompasses a broad range of activities that all LHJs engage in to some extent. Some LHJs have dedicated one or more staff in a separate assessment unit, some have one staff member with multiple roles that include assessment, some have program staff performing assessment functions within their programs, and some perform only the assessment activities that are required by categorical funding streams, e.g., state tobacco settlement funds.

"You do these things [assessment activities]; you don't consider them assessment."

Most LHJs would like to use data to drive decisions and influence their communities, would like to know more about their population(s), and would like to tailor their programs based on assessment results. About half of the LHJs have been able to make this happen to some extent. None has yet been completely and fully successful in realizing its vision for assessment. Some believe the obstacles to conducting and using assessment are too great to overcome, especially since they no longer receive any direct funding for assessment from the state.

The AIA Steering Committee specifically excluded program evaluation from this review in order to keep the focus on community health assessment. However, when LHJs were asked

what they would do in addition to their current assessment activities if they had additional capacity, some LHJs said program evaluation is the biggest need. The ability to develop local health indicators was the other capacity mentioned most frequently.

Some LHJs have identified local health indicators through assessment, a few are currently trying to identify local indicators, and a few are using the indicators they have used for years and would like to have the time/capacity to revisit their chosen indicators. Other LHJs did not mention health indicators.

"We would like to do an indicator report for the community, but we haven't chosen indicators."

Some LHJs are strong in gathering and analyzing data and preparing reports but weak in engaging the community; others are strong in mobilizing their community but rely on readily available data and analysis because they lack expertise in gathering and interpreting data. Some LHJs have strengths in both preparing and presenting data, but most LHJs fall towards one end or the other along the continuum between preparing reports and mobilizing for action.

Some communities are organized in a way that makes it easy to gather stakeholders together; other LHJs face significant geographic, cultural, or other barriers that make it difficult to bring the community together around health issues. These LHJs focus their efforts internally or with the agencies they connect with on a regular basis or believe it is beyond their capacity to engage in community mobilization activities. Some LHJs have close links to other LHJs that are committed to assessment, and they share resources. There are a range of permutations in addition to these examples.

From the telephone interviews, it appears that optimal implementation includes the abilities to:

- Accurately describe the community and its sub-populations
- Use quantitative and qualitative data
- Present the data in compelling ways, e.g., producing GIS maps, easy-to-read fact sheets, or web postings
- Mobilize others to take action based on assessment data

FACTORS THAT INFLUENCE COMMUNITY HEALTH ASSESSMENT CAPACITY

Key Findings

Tipping Point: When LHJs see assessment as an investment that leads to increased resources or improves their ability to do more with fewer resources.

Tipping Point: When communities come to view LHJs as vital partners because of their assessment capacity.

Most Directors who have kept assessment as a priority in their LHJs reported that they embraced the Public Health Improvement Plan (PHIP) philosophy.

“Champions” are important in starting and growing assessment capacity.

The above “tipping points” refer to the two biggest changes in attitudes and awareness that support an ongoing commitment to community health assessment capacity. LHJs that see community health assessment as a vehicle to prioritizing limited resources, garnering additional resources through grants and other sources, securing public and/or Board of Health support for LHJ programs, improving coordination of services, or pooling resources with community agencies are most likely to find ways to make assessment happen. When LHJs have demonstrated their knowledge of the community and its health issues to external audiences, they are often perceived differently by the public and assume a broader public role. Those LHJs that reported a strong commitment to assessment often also reported that, as a result of assessment, the LHJ has come to be viewed more positively and is much more vital to community decision-making. This external expectation that the LHJ will be “at the table” in community decision-making and will bring data about the community and its health reinforces the commitment to assessment capacity.

“As finances get tighter, we need to pool resources. For example, our assessment on family planning services showed that the population preferred to get their services from Planned Parenthood rather than the Health Department. As a result, now Planned Parenthood rents our space, provides services, and allows me to pull my staff out to do other work. The clients benefit, our partner [Planned Parenthood] benefits, we benefit.”

"The profile and value of the Health Department and Public Health in this county has been raised [as a result of assessment]."

LHJs were not asked directly about the Public Health Improvement Plan (PHIP) in the telephone interviews. However, it is noteworthy that those directors who felt most strongly about the importance of assessment frequently also mentioned their support for the PHIP philosophy (or the 1988 Institute of Medicine report on the future of public health).²

"The Institute of Medicine's report was absolutely on target."

When LHJs were asked to describe the evolution of their assessment capacity, those interviewed often mentioned specific personalities who had a primary role in shaping assessment. These people -- sometimes Health Officers, sometimes Directors, sometimes assessment staff or contractors -- convinced others of the importance of assessment. These "assessment champions" inspired others to become champions in their LHJ. For example, one champion was mentioned by four LHJs as having influenced their belief in the importance of assessment. Clearly, having a vocal and visible proponent of assessment is a factor that influences LHJ community health assessment capacity.

Evolution of Assessment Capacity

Key Findings

Nearly all LHJs have lost funding and assessment capacity since the mid-1990s.

Whether LHJs used staff or consultants to conduct the assessments funded by DOH in the mid-1990s does not appear to be a determining factor in whether the capacity was maintained.

LHJs were asked about the evolution of the assessment function in their LHJ in the hopes of identifying common trends in how assessment evolved over time. Clegg & Associates found that there are few commonalities. Assessment capacity in some LHJs has little to do with how the 1990s assessments were conducted. In many of these cases, the LHJ Director position has turned over or other staff involved in the assessment are no longer employed by the LHJ. A few LHJs reported knowing little about how assessment was conducted in the mid-1990s. A few LHJs reported that they took the opportunity to use the state resources and training that were provided in 1995-1997 to gain staff buy-in and build assessment skills and that they believe this has resulted in greater assessment capacity. A few have continued primarily using contractors for assessment. A few LHJs have seen their capacity fluctuate

² "The Future of Public Health," Committee for the Study of the Future of Public Health, Division of Health Care Services, Institute of Medicine, National Academy Press, 1988.

over time; others have seen a steady decline since the mid-1990s. Nearly all reported that they have lost capacity since the state stopped providing funding for assessment.

Importance of Assessment

Key Findings

All five large LHJs consider assessment to be “mission critical.”

All 10 medium-sized LHJs consider assessment to be very important or mission critical.

Fifty-five percent of small LHJs consider assessment to be very important or mission critical; 35 percent consider assessment of moderate importance or unimportant (10 percent did not answer).

For LHJs that did not consider assessment very important, the main reason cited is a lack of discretionary funding.

LHJs were asked to rate how important the assessment function is to achieving the LHJ's goals, on a scale of one to 10, with one being “not at all important” and 10 being “mission critical.” Here are the results:

LHJ RATING OF ASSESSMENT IMPORTANCE

Assessment Importance rating	Number of LHJs	Percentage of all LHJs
9-10	19	54%
7-8	7	20%
3-6	4	11%
< 3	3	9%
No Answer	2	6%

Those LHJs that consider assessment to be mission critical expressed a variety of reasons for their ratings:

"Ensuring the availability of assessment services internally and externally has helped us achieve growth, understanding, and embracing of priorities."

"Assessment is increasingly important to set priorities as revenues decline."

"You must take public health programs to the community you are in, and you must know the community you are in before you can take programs to them."

"Without assessment, we would lose the big picture. Assessment also provides accountability, which is especially important at the state level as a basis for funding."

"Our LHJ's goals and strategic plan are the [Public Health] Standards so assessment is a 10. Also, we are service providers too, and finding out if we are doing the right services makes it a 10 too."

"Assessment can answer the question, 'Where do we go next?'"

For LHJs that did not consider assessment very important, the main reason is a lack of funding. Many smaller LHJs are running on bare bones staff, a few do not have Administrators and a few have Health Officers who are available only a few hours per month. Because nearly all of their funding is program-specific, assessment is an unfathomable luxury. A few noted that if they had discretionary funding, they might have rated assessment higher.

"Assessment is so far on the bottom of the pile, I can't image what I'd do [if I had more capacity]."

"When it all [assessment] started out, it seemed like we'd be able to choose what to do based on our assessment. But all our funding is categorical (e.g., so much for HIV/AIDS, so much for tobacco). Our data

shows diabetes is a real problem, but we don't have any money to respond to this."

"Assessment is a zero, unless it is funded. We don't have [LHJ] goals; our goals are categorically [funding] driven."

Community Health Assessment Impacts

Key Findings

LHJs reported a number of positive impacts as a result of assessment, including:

- Increased resources
- Increased effectiveness
- Better decision-making
- Increased ability to act proactively
- Increased visibility
- Improved services
- Increased collaboration and cooperation
- Improved community perception of LHJ
- Increased awareness of public health issues
- Decreased influence of politics on LHJ priorities

A few LHJs reported improvements in oral health access or services based on assessment data. This seems to be an easy place to start for some LHJs.

A few LHJs reported having completely changed what they do as a result of assessment, including changing funding priorities, organizational approach, and program delivery.

"Assessment resulted in a restructuring of how we did business. Our staff went from specialists to generalists. Linkages were created. We went from a people-dependent, turf war situation where everyone was competing for limited resources to a cooperative system. Staff like to come to work now."

For most LHJs, however, assessment has yielded important but incremental results. A few LHJs saw their first impacts in assessment from addressing oral health issues. This may be because the need to address oral health is evident to LHJ staff, the data on dental access and dental caries is relatively easy to gather and analyze, and there is little controversy to prevent community members from engaging in the discussion. As a result, LHJs have begun ABCD programs, provided sealants through schools, and increased Medicaid patients' access to dental care. The following are other examples from small, medium, and large LHJs of changes resulting from assessment:

- Healthy Youth Survey results combined with Driving Under the Influence (DUI) statistics led one LHJ to secure both grant resources and additional funds from their Commissioners to hire a .85 FTE DUI Coordinator.
- The mid-1990s assessment showed that urgent health priorities and needs included breast cancer and cardiovascular issues. The LHJ instituted an annual health fair for women.
- Maternal and Child Health assessment information regarding the Native American population was presented to the Congressional delegation. This resulted in federal funding for a local Tribe being secured and maintained.
- A report on health disparities and diabetes led to services being provided to Latinos in senior centers one day per week.
- As a result of a chronic disease report, one LHJ chose two chronic disorders as priorities and allocated additional LHJ funding for prevention.
- Moped injuries were a major concern to the community, and community members advocated that mopeds be banned. LHJ data on injuries showed that bicycle injuries were just as much a problem. As a result, instead of a ban, the community instituted an educational program for drivers and riders.
- Assessment led to funding for breast and cervical health screenings.
- A child death review on a drowning led to a life jacket loaner program.
- A child death review led one LHJ to provide a training module, which resulted in an Emergency Medical Services (EMS) policy change regarding investigations of infant deaths.
- WIC and First Steps programs delivered more current information more aggressively when assessment showed high rates of unintended pregnancy.
- The LHJ successfully completed a very complicated process (including Board of Commissioners approval) to open the first new methadone clinic in Washington State in 30 years. According to this LHJ, "Our success began with data."
- The Board of Commissioners had discussed shifting environmental health out of the health department. Assessment data allowed the Board to develop an enhanced understanding of environmental health, and the Director succeeded in keeping it within the Health Department.
- When the tobacco program was in its infancy, the Board of Health asked whether the public health department was just beating people over the head about quitting smoking. A survey showing 70 percent of respondents wished they could quit but had not been able to quit. This information was key to changing the Board's attitude.

Over time, LHJs have seen their role in the community change, based on their assessment activities.

“Assessment has helped the community understand a big part of what the public health department does.”

“Before assessment, the community saw the LHJ as authoritative, e.g., kicking people out because their septic systems don’t work. Now they see us as a community partner.”

“The Health Department is now seen as a leader in solving community problem -- an objective convener, believable, and trustworthy.”

Resources Necessary for Conducting Community Health Assessment

Key Findings

Every LHJ said they need more money to conduct community health assessment.

Other frequently-cited important resource needs fell into the following categories:

Staff capacity

DOH support

Technology and data

Community partners

Adequate funding is the resource that all LHJs agreed they need in order to conduct community health assessment. Nearly all LHJs had more assessment capacity when there was dedicated funding provided by the State for assessment in the mid-1990s. Stable funding from year to year is important for assessment capacity so that data gathering can be maintained over time, allowing comparisons of previous data and aiding in the identification of trends.

In addition to funding, LHJs need staff capacity to undertake assessment. Staff capacity includes dedicated staff time, staff with assessment skills, and support for assessment from top Administration within the LHJ. Some LHJs noted specifically that they need access to a part-time epidemiologist either on staff, on contract, or through DOH.

"We need qualified people with an interest in assessment. You can't just give it [assessment] to anybody to do."

Support that LHJs said they need from DOH includes:

- Maintaining the current assessment liaison and Vista coordinator positions
- Continuing to convene the quarterly regional assessment meetings and to provide other peer learning opportunities
- Providing tools, such as Vista
- Offering training and technical assistance on using assessment tools and conducting assessments
- Providing reliable data
- Providing easy-to-use county-level and sub-county data
- Setting standards and policies for assessment
- Maintaining the WA-ASSESS listserv

A few small LHJs said they need DOH to provide and analyze data for them. They believe that they will never have the capacity for these activities.

"It would be helpful if DOH provided county-specific data when they produce their State of Health in Washington report every few years."

LHJs also need technology and data for assessment. Common data sources include vital records, the Behavioral Risk Factor Surveillance System (BRFSS) survey, the Healthy Youth survey, census data, and data from LHJ programs. Smaller LHJs, especially those in rural parts of the state, have different data needs than urban, large, or medium-sized LHJs. When population numbers are small, data can be easily misinterpreted, e.g., a 50 percent increase in multiple births if there are two sets of twins born one year and three the next. It is important to look at data over a five-year period, rather than annual numbers. This makes historic data very important to smaller LHJs and skill in interpreting data critical. Medium-sized and larger LHJs are more likely to need data on county sub-populations in order to conduct their assessments.

"Vista is absolutely critical to me."

Some basic technology is needed for assessment; beyond that, more advanced technology can significantly improve an LHJ's ability to gather, analyze, and disseminate assessment data. For example, database and analysis software, web access and websites for posting assessment results, and Geographic Information System (GIS) mapping capability can all increase the ability to undertake and make an impact from community health assessment.

"Lots of our constituents can map their data; we can't. It is so much easier to understand when mapped."

Community partners are a vital resource for community health assessment. To be successful, LHJs must strengthen relationships with current partners and reach out to new community partners in order to have the most impact. In some cases, LHJs have created committees made up of community partner representatives to advise and take action on public health issues. A few LHJs reported that they have expanded their connections to law enforcement, emergency services, and even the FBI through bioterrorism efforts (see Community Stakeholders section for more information).

"The ability to build constituencies for our work will have a great impact on our future."

Obstacles

Frequently-Cited Obstacles

Lack of any of the above necessary resources, especially time and money

Lack of understanding of what assessment is and what it can do

Disconnect between the issues stakeholders think are important and what the data shows is important

Long-term staff/Board of Health/community partners who believe assessment is unnecessary (i.e., they know their community and its health problems)

Resistance to change

Competing priorities

Lack of a clear vision for community health assessment from DOH

Assessment is time and resource intensive. Some LHJs find data gathering and analysis overwhelmingly resource intensive while others find community mobilization to be the most resource intensive. A few LHJs believe they have the tools, structure, and skills to carry out assessment and are only lacking time and money.

Competing priorities are the biggest challenge to LHJs finding the time and money for assessment. Some LHJs have assessment staff responsible for multiple roles, and assessment is often put on the back burner for other, more urgent priorities.

"BT [bioterrorism] has driven us lately. We haven't had an assessment team meeting since it [BT] started. We are focused on crisis-oriented work – BT, smallpox, SARS."

Examples of the disconnect between the issues stakeholders think are important and what the data shows is important include public health issues covered by the news media, e.g., West Nile virus, SARS. Influential stakeholders may be more aware of a public health issue because of their personal experience, and they may be effective in making that issue an LHJ priority regardless of data that show the number of people impacted is minimal. In contrast, a constituency group may be very vocal about its needs when it makes up a small proportion of the LHJ population.

Board of Health members, LHJ staff, or community agency representatives who have lived and worked in the same community for a number of years are more likely to believe they know their community and their clients, particularly in smaller LHJs. LHJs reported that often these people believe assessment is unnecessary or only needed every few years. People who have served in the same position for a long time are also more likely to be resistant to change in general, and assessment involves changes in thinking and action that may seem threatening.

Some LHJs believe that DOH does not truly value community health assessment since it no longer provides funding for assessment. Others are confused by DOH's message on assessment – it is included in the standards as a priority, but it is not prioritized in funding provided to LHJs. A few LHJs said they were concerned that they would lose credibility in their community if DOH waffles on their commitment to Vista, the liaison position, or other supports it currently provides. A few LHJs saw no obstacles presented by DOH.

"If we say we don't have it [the requested data], and our stakeholder goes onto the [DOH] state website and finds it, we lose credibility."

"I get the sense from DOH that assessment within DOH isn't a coordinated function. I don't think they see it as a guiding light, like we do."

ADDITIONAL OBSTACLES FOR SMALLER LHJS

Smaller LHJs are less likely to have identified local health indicators and have to spend more time "fishing around" to discover what data is important. Most larger LHJs have developed community health indicators that can be reported regularly and provide a good snapshot of what is happening in public health. Medium and small-sized LHJs would benefit from having this kind of standardized approach to what data they gather and report, but they struggle to identify the key indicators. A lot of data must be sifted through in order to determine what is most important. Additionally, LHJs need to engage the community to develop consensus as to which indicators are key. This process takes a great deal of time and resources.

Smaller LHJs discussed the difficulty of recruiting people with assessment and/or data analysis skills to work in isolated rural areas. They said they are less likely to have a pool of qualified candidates with assessment skills and less likely to have the resources to offer salaries competitive enough to draw skilled personnel.

Some smaller LHJs noted that multiple assessments in their community (due to DOH and other state agency efforts/requirements) were an obstacle to their work. Community providers can get into turf wars, stakeholders may view the LHJ's assessment work as duplicative, and small populations can get tired of answering surveys, which may diminish the quality of the data collected.

"We need state-level direction to collaborate all the assessment requirements, such as tobacco, mental health, etc.)."

Funding Community Health Assessment

Key Findings

Most LHJs use some of their Local Capacity Development Funds for assessment.

Other funding sources include grants, contracts, county general funds, and local funds.

A few LHJs are creatively using their bioterrorism (BT) funding and mandates to further their assessment goals. But for most LHJs, BT takes staff time and resources away from assessment.

As stated earlier, funding is the most difficult challenge for LHJs conducting community health assessment. Some LHJs do not set aside any funding for assessment. Of those that do, the most common source is Local Capacity Development Funds (LCDF). These discretionary funds are an LHJ's most precious dollars, as they are often the only funding that is not tied to a particular program or purpose. Some LHJs that fund assessment primarily through LCDF were asked what percentage of their LCDF they use for assessment; the answers ranged from 10 to 50 percent.

"You can look at that source of funding [LCDF] every year and ask, 'is it the best use of our most precious funding?'"

Some LHJs have been successful in obtaining grant funding for their assessment work. Examples include a DOH grant for childhood immunizations, a CDC grant for environmental health assessment, and a critical access grant. For at least one LHJ, grants are the primary source of assessment funding. The weaknesses of this grant dependence for them is that the grants will come to an end, and the LHJ doesn't know where it will find future funding. Also, grant dollars generally drive the subject matter of assessment.

Ten LHJs reported that they receive county or local funds for assessment. Five LHJs have received funding from local hospitals, and five have contracts to pay for their assessment

work. A couple of LHJs have used bioterrorism funds to build their assessment capacity, one LHJ gets assessment funding from birth and death certificates, and a few operate on an indirect (i.e. overhead) charge to all LHJ programs.

The following table shows the funding sources reported by the 34 LHJs that participated in telephone interviews. LHJs that reported multiple sources are counted more than once so the numbers will add up to more than 100 percent of all LHJs.

LHJ REPORTED SOURCES OF ASSESSMENT FUNDING

Source	Number of LHJs reporting this source	Percent of all LHJs
LCDF	22	63%
Grants	8	23%
County or local funds	10	29%
Hospital	5	14%
Contracts	5	14%
No assessment funding	4	11%
Other	3	8%

Structure and Staffing of Assessment Function

Key Findings

Most LHJs have less than one FTE working on assessment.

In small LHJs, the LHJ Director is often the only assessment staff.

The range of skills that are helpful for assessment personnel to have are too broad to be manifested in a single person.

All LHJs perform assessment activities within some programs. Some LHJs add to this an overall assessment function.

Public Health – Seattle and King County has a staff of 30 FTEs working on assessment. The other four large LHJs have fewer than five assessment staff each. A few medium-sized LHJs have between one and two FTE assessment staff. All other LHJs have less than one full-time staff member dedicated to assessment, including some that have no assessment staff.

For most of the LHJs who have less than one FTE, the assessment staff have other LHJ responsibilities (i.e. assessment is not their only job function). Assessment staff who have other health department responsibilities are most likely to see the competing priorities as an obstacle; a few see it as a benefit as they are able to stay connected with other areas.

Assessment encompasses a range of activities, and LHJs must have a range of skills in order to implement it optimally. The range is far too broad for any one person to possess. LHJs must either have a large assessment staff, find a way to supplement assessment staff with others who have complementary skills, or just accept that they will be weak in some areas of assessment. For complementary skills, some rely on DOH expertise, some network with other LHJs, some hire contractors, and some are able to access county personnel. The following is a list of skills LHJs said are important for assessment staff to have:

- Experience in assessment
- Statistical analysis
- Epidemiology knowledge
- Field experience in public health
- Good people skills
- Understanding of how to implement health improvement strategies
- Being able to focus/prioritize limited time
- Community connections
- Marketing skills

Every LHJ is required to perform assessment activities in order to receive certain programmatic funding, e.g., Maternal and Child Health, Tobacco Prevention. Some LHJs focus their assessment functions within these programs; other LHJs add an overall assessment function to look at cross-program data. “Overall” assessment appears to be more likely to result in changes in policies, programs, and resources. This may be due in part to the fact that it is a more visible change factor when it is not restricted to a particular program.

The advantages of overall assessment include the cross-program perspective, resource efficiency, and independence. Disadvantages include the potential for isolation and for assessment to be more vulnerable to budget cuts because it is viewed as overhead.

Overall assessment staff are most likely to report directly to the LHJ Director. The advantages of this structure are increased access to the Director, increased visibility, and, usually, increased contact with the management team. Disadvantages can include less direct supervision and isolation from other LHJ staff.

Constituencies for Health Assessment Information

Key Findings

Most LHJs spend considerable time responding to data requests, which, while important, limits time available for proactive assessment activities.

Some LHJs reported that, as they improve their assessment capacity, the number of requests for data increases.

Most LHJs reported that stakeholders are interested in assessment data primarily for funding, e.g., grant writing, and justifying their budget. Secondary uses include program planning and program improvement.

Some LHJs have a task force or community leadership group to which they bring assessment results. This is often a successful vehicle for community action based on health assessment data.

The following groups were identified by LHJs as stakeholders for assessment data:

- Anyone writing a grant
- Board of Health
- Internal health department staff including environmental health, communicable disease, and program staff
- Community groups
- Social service agencies
- Hospitals
- Healthcare providers
- Schools
- Students
- Elected officials/politicians
- Press
- More recently, law enforcement and emergency preparedness agencies, because of the current bioterrorism emphasis
- Other county and city departments, e.g., parks

Responding to data requests can take an inordinate amount of time, and as LHJs begin to be seen by the community as the repository of data, the number and complexity of requests can increase.

"A data request that looks small gets big fast."

"There is a growing demand for assessment internally and externally."

The question of what to do with assessment data, other than responding to requests, has been answered by some LHJs through the formation of a stakeholder group to which assessment data is presented on a regular basis. This group can then decide how to act upon the data, which may include advocating for changes in LHJ priorities or funding, program or policy changes in community agencies, public education efforts, or other actions.

Site Visit Snapshots

The site visits to six local health jurisdictions yielded a great deal of useful information relating to what makes some LHJs particularly successful in their implementation of community health assessment. The diversity among the sites in geography, budget size, approach to staffing the assessment function, and organizational structure increases the chances that other LHJs will be able to adapt some of these practices to their own settings.

The descriptions that follow provide highlights of the community health assessment practices under way at each of these LHJs. Highlights focus on what is working in each site and what are the factors that contribute to success. In each site, there was particular energy and enthusiasm around specific factors. The highlights presented here do not reflect the full range of each LHJ's community health assessment efforts; rather, they focus on some of the factors which LHJ staff spoke most passionately about or which seemed most instructive to others.

Island County Health Department

The experience of Island County Health Department demonstrates that visionary leadership from the LHJ director and the health officer, combined with dedicated and skilled staff committed to community mobilization, can have a profound impact not only on improving public health but also building both political and financial support for public health.

The objective of Island County Health Department's director, Tim McDonald, is "Putting the public back in public health," believing that monetary resources and political power derive from community involvement. Assessment, the LHJ director asserted, is not a "pass along function." There is more to assessment than responding to data requests. It is community capacity building.

Island County Health Department has 1 FTE dedicated to community health assessment, and 1 FTE dedicated to environmental health assessment. On the community health side, Carrie McLachlan serves as Assessment and Community Development Supervisor, committing .75 FTE of her time to assessment activities and .25 FTE to contracted fundraising for the local hospital. Carrie is supported by a .25 FTE assistant. On the environmental health side, Celine Servatius comprises 1 FTE to support the community mobilization work of the Health Department in the environmental health arena. Carrie reports directly to the Health Services Director, and Celine reports to Environmental Health Director Keith Higman. The Health Department generally also hires one contractor per year, such as a biostatistician or graphic designer, depending on what additional support is needed in a given year.

Two community groups, the Community Health Advisory Board (CHAB) and the Environmental Health Assessment Team (EHAT), are the keys to success in Island County. The CHAB is a 21-member community advisory group first formed in 1993 to serve as a "voice of the people" and to present and recommend policies to the Board of Health. The EHAT is a 26-member advisory group formed in 2002. CHAB members initiated the

formation of the EHAT, believing that the same kind of community role was needed in local environmental health. The EHAT continues to work under the auspices of the CHAB.

The responsibility of the CHAB and EHAT is to drive and prioritize public health issues. The CHAB works on a three-year cycle in regard to the issues it takes on. Members find this to be an advantage in terms of maintaining morale and momentum – if significant progress is not achieved on an issue one year, they know that they will have an opportunity to revisit it again. The groups meet monthly and serve three-year terms. Members are told when they join the groups that the three-year commitment is expected, and several members have served for multiple three-year terms. New members are actively recruited, and there is a competitive application process. Community interest is such that membership on the groups has become something of a community status symbol.

Current CHAB and EHAT members nominate new members from the pool of applicants, and the Board of Health appoints the new members. The advantage of Board of Health appointments is that, when faced with difficult issues, the Board of Health gets its information from an advisory group that is appointed by the Board and that reports directly to the Board, rather than from the health department.

Health Department staff described the CHAB and EHAT as broad-based community groups that provide the community with a place where they can have a voice and make an impact on public health issues. Both the CHAB and the EHAT are staffed by Health Department assessment staff; staffing these community groups is a primary responsibility of the assessment staff. The Health Department director recognizes that community mobilization work is time and resource intensive, yet he is willing to make this investment, believing that such an investment is critical to achieving the Health Department's mission. The Health Department is also willing to invest resources in CHAB and EHAT members, sending them to trainings and speaking events. The benefit of the investment is seen when the Health Department's constituency starts advocating for its issues.

According to CHAB and EHAT members, successes include:

- Expansion of the Board of Health from three county commissions to also include a mayor, the hospital district commissioner, and an ex officio member from the Navy Hospital
- Funding for an early intervention/home visiting program from Island County
- Increased awareness of public health issues among Board of Health members
- The ability to tackle politically difficult issues that the health department might not otherwise be able to move

Members also pointed to factors that they believe have contributed to their success:

- A diverse membership that is passionate about public health issues
- The professional expertise of members
- Good staff support and coordination – having people who move things along so people keep coming back
- The opportunity for diverse members to get to know each other as individuals, which facilitates a consensus building approach to decision making

Likewise, Health Department staff were clear about what they believe it takes to make such community advisory groups work:

- LHJ staff need to be at the table

Both the Health Department director and the Health Officer regularly attend CHAB and EHAT meetings. The Health Office is also active as secretary to the Board of Health, and he serves as the “institutional memory” of the CHAB, since he was involved from the beginning. A retired, half-time health officer, he also manages the CHAB and EHAT websites. Staff also need to be willing to listen to community interests and concerns. According to the Health Department director, “People don’t trust you until you’ve been at the table.”

- LHJ staff need to respect community groups as “independent power centers”

Staff need to recognize that community members hold different opinions from those of the LHJ. Staff need to accept the fact that policies may sometimes be pulled in a direction that they would rather not see: “It is their team, not the health department’s team. We anticipate that they will come up with issues that the health department may not agree with, and that’s okay. We have discussed this with them and recognized that we have different roles.”

According to those interviewed, the CHAB has made a significant contribution in resource development within the community. When the Health Department announced that it would not have funding for the BRFSS, the CHAB helped pull funding together from the community. The CHAB was also instrumental in applying for and receiving the CDC, Center for Environmental Health, 10 Essential Environmental Health Services Capacity Development Grant that funds Celine’s position. The CHAB mobilized community members to write letters of support for the grant application. Currently, the CHAB has a subcommittee on public health funding and is investigating the possibility and feasibility of approaching the Board of Health to increase the sales tax by .2 percent, as authorized by the state legislature, to fund public health. In regard to other funding sources, the Island County Health Department has received other county funding for assessment.

For Island LHJ, community health assessment is all about community mobilizing. Internally, there has not been as much of an emphasis on using assessment data to inform program policy and improvement, particularly within environmental health. Environmental health was described as working within a regulatory power structure with a systems approach. Environmental health has not historically considered or collaboratively involved the community, but through the EHAT work, the LHJ is attempting to demonstrate the benefits of community involvement.

The Island County Health Department does publish periodic reports on specific health issues. In keeping with the collaborative relationship between the Health Department and the CHAB, recent reports note that they are “brought to you by the Island County Health Department and the Island County Community Health Advisory Board.” A letter from the CHAB chairperson to the community introduces each report.

Jefferson County Health and Human Services

A motto for the Jefferson County Health and Human Services (HHS) assessment success may be “look for the opportunity in what people are interested in.” This attitude has influenced both the internal staffing and the success in gaining support from the community that Jefferson HHS has experienced.

Jefferson HHS staff admit that, when the State mandated and funded assessment in the mid-1990s, “we didn’t get it. There was a lack of understanding about why we were doing this.” Then, about two or three years ago, Director Jean Baldwin realized that they had two programs they believed exemplified best practices but no community data to confirm that belief. She hired Dr. Christiane Hale to get people excited about the data, even though what was available at that time was very thin. It was an experiment to see whether assessment could be done and whether it needed to be done.

Using the Washington State Survey of Adolescent Health Behaviors 2000 dataset, Dr. Hale facilitated a two-day data exercise with the Director and staff from drug, alcohol, and substance abuse prevention, tobacco prevention, communicable disease, and maternal and child health. Looking at the school data made both Jean and prevention staff member Kellie Ragan fall in love with data: “Now we understand it, believe it, and care about it.”

Kellie surfaced among the staff as a “numbers person” and quickly developed a passion for assessment. Just as quickly, Jean added responsibility for assessment to Kellie’s job description. Kellie works full-time and has several responsibilities in addition to assessment that take up 50 percent of her time. There are no other assessment staff. Jefferson HHS continues to use Dr. Hale on a contract basis, especially for her statistical skills. The staffing of assessment is challenging: “I haven’t been able to free Kellie enough from her other work, and assessment comes at the expense of other programs.” Jean also would have liked to have had a DOH regional support person available so that she would not have had to hire Dr. Hale. Another challenge is that Kellie does not have any assessment peers within her LHJ to provide feedback.

Jean believes Kellie’s strengths in number crunching and writing, combined with the intuition developed through substance abuse and tobacco prevention field experience and 10 years working with logic models, more than make up for her lack of educational background in assessment or statistics. Based on Kellie’s field experience in working with youth and clinical training in mental health counseling, she is able to explore possible patterns and relationships in the data. According to Jean, “I think her field experience makes her analysis of the numbers different (in a good way) than what you would get with an epidemiologist.” For example, considering the possibility that people reporting smoking, alcohol use, heavy drinking, or being overweight on the BRFSS may be self-medicating, Kellie would look to see the relationship between these factors and indicators of poor mental health or a history of abuse.

Jefferson HHS has invested in Kellie’s assessment skill development, including hiring Dr. Hale as a mentor, and giving Kellie time to attend DOH trainings and regional assessment meetings. Through the quarterly assessment meetings, the face-to-face interaction makes it easier for Kellie to email and call others when she needs help: “I have not had people say no

[when I've asked for help]." Jefferson HHS is conscious of "not reinventing the wheel" and adapts examples from other LHJs whenever possible, especially King, Pierce, and Snohomish Counties. Kellie also learns a lot from the WA-ASSESS listserv, especially the "data dumps" that Mary Ann O'Garro (Thurston) puts on it. Jefferson HHS is collaborating with Clallam and Kitsap to share data and develop local indicators.

Kellie's drug and alcohol background served Jefferson HHS well when BRFSS data came back and "the story it told was awful. Health disparity is a huge issue. If you are poor, you don't have health care or housing. If you have kids, you are poor." Because of this, Jean has moved away from the 2010 model (Clark County) and the CDC model towards the DASA model. The DASA model works because it acknowledges a balance that always includes the positive. "I have kids [in this county] who binge drink but go to Harvard. There is resiliency here. I have to show people with PhDs who have kids why they should stay here. It isn't hopeless." Jean is still looking for a good data source on assets or positive indicators.

To engage the community, Jean spent a year "softening up the community leadership; not health folks, but people like the county manager and the city manager." Vital statistics information was good, but it did not lead to action. It also did not interest these community leaders. At the time, everyone was looking at criminal justice and how much money the County was spending on it. Jean used data on things like domestic violence, child abuse, and substance abuse to show the link between criminal justice and public health.

"The hook to policy makers came from getting non-public health data, such as child abuse referral rates, drug and alcohol statistics, and violence statistics, and linking it to health data."

Jean convinced the City of Port Townsend to give the Health Department \$25,000 to conduct a BRFSS. Jefferson HHS customized the survey by adding violence modules and all the questions it could find on mental health and substance abuse. This was at the same time as the Census, and now it has three main banks of data: the BRFSS, census data at the census tract level, and the Healthy Youth Survey. Jefferson HHS also has an annual commitment from the City to contribute \$25,000 for its assessment work.

Jefferson HHS is beginning to see results from its assessment practice, including:

- Increased LHJ Director and BOH understanding of and agreement on community health priorities
- Increased community willingness to look at accurate data
- Decreased influence of personal politics on community health decisions
- Increased LHJ staff and community awareness of priority issues
- Increased resources to priority programs, e.g., added two Maternal and Child Health staff
- Increased levels of service to priority populations, e.g., Best Beginnings program expanded to all births

Jean believes Jefferson HHS has been successful in “throwing a safety net over maternal and child health.” If Maternal and Child Health (MCH) services are cut, the community will be vocal in its opposition because community members understand the importance of MCH programs to the community’s well-being. Jean believes the community and the LHJ staff are beginning to see more connections between what they do, which is leading to better coordination. Communication “about what we are seeing” has improved.

In April 2003, Jefferson HHS released a “Health of Jefferson County Report.” The report is similar to the “books” other LHJs produced during the mid-1990s. It is the culmination of two years’ work by a community partnership made up of the City of Port Townsend, Jefferson General Hospital, Olympic Area Agency on Aging, Washington State University, Olympic Community Action Program, the county Law and Justice Committee, Jefferson County Health and Human Services, and citizens. Jefferson HHS recently sponsored a full-day community leaders forum to present the data and hold discussions about what the data mean and what should be done. Over 100 people attended, including many elected officials. The purpose was to hand over the data – to give it to the community to own and act upon: “It becomes their [the community’s] data, we don’t own it.” Small groups organized around issues the larger group prioritized, and each group had a facilitator and a note taker. Jefferson HHS plans to convene each of these groups at least one more time. For those who want more detail than is covered in the book, they will provide web access and compact discs.

Kitsap County Health District

The Kitsap County Health District has managed to turn two existing assets – a county with a good information technology system and a community experienced in collaboration – into key strengths for its community health assessment efforts. The District has also faced two common obstacles to assessment – politics and tradition – and addressed them head on.

In some ways, Health District Director Scott Lindquist is in an enviable position. Less than two years ago, he stepped in as Administrator and Health Officer for a Health District that had some real strengths. Perhaps in part due to a strong military presence, Kitsap County has historically had a good information technology system. According to Dr. Lindquist, County government is very data driven and County Commissioners are data savvy. The previous Director and Health Officer, Dr. Willa Fisher, was also a big supporter of using technology. The District has been able to capitalize on this strength, and expand it, in order to support decision-making based on data.

Dr. Lindquist has increased staff capacity to use technology. Each of the District’s Divisions (Administrative Services, Family & Community Health, and Environmental Health) now has a full-time Information Service Specialist (ISS) to provide technical support. The availability of technology and the expertise to use it have made it possible for the Health District to function as a central repository for county data, and the District has become known as a primary resource for data.

Assessment staff in the Kitsap County Health District are part of the Administrative Services Division. Staff include Hilary Metcalf, an assessment coordinator who works full-time but also has bioterrorism responsibilities, Scott Horn, a full-time ISS, Dr. Christiane Hale, who

works a few hours per month on epidemiology, and a very part-time support staff person. Hilary Metcalf directs and prioritizes the assessment work. Scott Horn provides support in data analysis and use of software, including Geographic Information System mapping. Dr. Hale is developing health indicators for priority issues. Assessment is funded using a combination of LCDF, grants, and contracts.

Hilary believes the assessment and bioterrorism functions complement each other. She was working on getting emergency response data together before bioterrorism became part of her job. Creating the infrastructure necessary for bioterrorism responsibilities has strengthened the foundation for assessment work as well. Bioterrorism coordination also gives Hilary more opportunity to engage with others, both within the District and in the community, which is one of her assessment strengths. She provides updates on assessment activities at monthly staff meetings, makes in-service presentations, participates in the Child Death Review team, attends community Funders and Planners group meetings, and participates in other agencies' assessments. According to the Director of Kitsap Community Services, which does a comprehensive needs assessment every three years with annual updates, "Hilary has been a critical part of this team for a number of years."

The District is currently working with the County Commission on Children and Youth to bring together experts, organizations, and key people of influence to share in a common analysis of new data and develop shared vision and priorities. According to Dr. Lindquist, "The biggest health problem in a community is getting agreement on the most important health priorities." Kitsap has an advantage in addressing this issue – an engaged community with a history of successful collaboration.

Much credit for the previous community collaborations goes to Dr. Fisher. When LHJs received state funding for assessment in the mid-1990's, Dr. Fisher brought the community to the table. According to stakeholders, it worked because there was trust, a shared commitment, and openness: "Throughout the assessment process, the Health District listened, asked stakeholders 'What do you need?,' and shared their data."

Darlene Kordonowy is the mayor of Bainbridge Island and sits on the Kitsap Board of Health. Prior to holding office, she sat on the Board of a social service agency on which Dr. Fisher also served. Through this agency, Ms. Kordonowy heard the District's presentation of assessment findings. Understanding the value of that assessment, this agency and others on Bainbridge have tried to build the same capacity (i.e. all agencies collaborating in gathering and depositing data centrally). According to Ms. Kordonowy, "Making this happen required that leaders in several organizations have the vision to make assessment a priority."

Another example of collaboration and data sharing is an agreement between the local hospital and the Health District. The hospital provides data to the Health District on emergency services, and the Health District analyzes the data and reports back to the hospital on any trends it uncovers. The hospital is currently looking into ways it can get information on disease surveillance to the District.

Assessment staff and Health District leadership maintain this community connection by sharing the data they have, listening to the community, and responding to community needs with good customer service. Dr. Lindquist is employing the same approach to overcome

two common obstacles, a politically charged Board of Health and staff or other stakeholders steeped in traditional thinking that does not value assessment.

Building relationships is key to overcoming both obstacles. That means open communication, attending staff/Board meetings, and seeing the provision of good customer service to staff and Board members as a part of the job responsibility. Assessment staff do not approach assessment from a research standpoint but rather from the standpoint of “How can we help you?”

Dr. Lindquist believes the best way to address these obstacles is head on. The Board of Health had a history of conflict because the Board comprises mayors and council members of four very politically disparate cities and the County Commissioners. In their roles as mayors, council members, and commissioners, they clashed on many non-health-related issues. Dr. Lindquist acknowledged this and asked the Board members to take off their other hats when they enter Board of Health meetings. He presented Board members with a report card on their performance over the past year and offered them the chance to evaluate his performance. This kind of open communication has broken down barriers and engaged the Board to the point where Dr. Lindquist can now present assessment information and ask the Board to set priorities and base the budget on these priorities.

Staff receive the same direct, open communication. Priorities are announced at an annual all staff meeting (before staff read about it in the newspaper). Staff are asked to identify ways they can support or address the priorities, with the knowledge that changes take place over time.

Kittitas County Health Department

The Kittitas County Health Department’s assessment efforts are especially notable in two areas: the existence of a long-term influential stakeholder group and the ability to creatively obtain data analysis assistance to complement the assessment staff’s strong community mobilization skills.

The Kittitas County Board of Health Advisory Committee (BOHAC) is a separate, non-profit, tax-exempt corporation. Formed by the Board of Health, its purpose is to assess the community’s needs (including but not limited to public health needs), recommend policies and procedures Kittitas County can implement to address those needs, and assist in assuring that the County is meeting the identified needs.³ The Advisory Committee acts in an advisory capacity to the Kittitas County Board of Health.

In a meeting with several BOHAC members, one member said he was a “newcomer” to BOHAC – having only served three or four years! Other members present have served on BOHAC since it began in the early 1990s. It is, according to one member, “an amazing conglomeration of people who feel they can make a difference.”

BOHAC began as a part of the Assessment Protocol for Excellence in Public Health (APHEX) process in 1992 when Dr. Jim Gale was the Health Officer for Kittitas. The

³ Kittitas County Board of Health Advisory Committee Bylaws.

group was set up to meet quarterly but chose to meet monthly. Dr. Gale encouraged them to develop a mission statement and become a 501(c)(3) non-profit corporation. In 1996, the Department experienced some turmoil when the Nursing Manager quit. Dr. Gale saw this as an opportunity to put the BOHAC to work.

BOHAC members conducted interviews, surveys, and other research and made recommendations on substantive issues such as whether Kittitas should be a health district or a health department, whether it needed an administrator, whether the Board of Health should be expanded, and whether LHJ staff salaries needed to be raised. The report was so thorough and strong that the three-member Board of Health agreed to all the recommendations, including expanding the Board of Health to five members. (Kittitas was the first county in the state to increase the size of its Board of Health.) Now, the Board of Health asks "What does BOHAC think?" before it makes decisions.

BOHAC members identified a number of reasons for the success of their committee:

- BOHAC members have a passion for public health issues
- Health Department staff have the same passion
- There is genuine respect between staff and BOHAC members
- BOHAC members have opportunities to make a difference
- BOHAC members are given real jobs to do, and they take those assignments seriously
- BOHAC meetings are not static: "If you miss a meeting, you lose out."
- "They [staff] occasionally brings us food."

Other factors in BOHAC's success are the connections and influence of its members. One member is the director of a developmental disability program and is also active in the Chamber of Commerce. Another has connections to agriculture and is a hospital district commissioner. One is a retired mental health and substance abuse program administrator who is also active in the League of Women Voters. Their connections help them bring issues and perspective both to the BOHAC and to their other affiliated organizations. For example, the League of Women Voters sponsored the recent Washington Health Foundation roundtables. A previous County Commissioner took the BOHAC model and spread it to other boards, including one addressing mental health. One member stated, "As a hospital board member, I knew we were spending lots of money on recruiting and retaining physicians. I brought this to BOHAC's discussion on physician access. Then I was able to take the sense of the community back to the hospital." Another explained, "BOHAC helps me understand what's really happening, i.e. the broad picture, rather than just what I hear from my clients."

Assessment Coordinator Jane Wright and Health Department Administrator Nancy Goodloe admit that they "do a lot of care and feeding" of BOHAC members. One BOHAC member described Jane as "the glue" that makes BOHAC stick by staying focused on the positive and the possible.

According to Nancy, "Jane is held in very high esteem in the community." Jane has served on many community boards and committees, and she has a great media connection. Two

weekly radio shows on different stations and a Health Watch column in the newspaper (which Jane alternates writing with the hospital) have given Jane credibility with the media and the public. This is helpful when getting assessment information out because “they repeat what I say without editorializing.”

Recognizing the importance of Jane’s community connections and faced with the fact that Jane wanted to work less than full-time, Nancy downsized her job by eliminating the non-assessment components, including oral health. Jane works 24 hours per week, and there are no other assessment staff. Jane’s strength is in moving the community to action. She readily admits to having no educational background in data collection or analysis and no real affinity for numbers. She and Nancy have been creative in gathering skills and resources from others to complement Jane’s abilities.

When Kittitas conducted the BRFSS, they contracted data analysis out to Public Health – Seattle and King County. David Solet from Public Health offered Jane the opportunity to build capacity by training with David as he did the analysis. According to Jane, “It was intimidating, but I did it.” Kittitas is now undertaking an immunization study. I thought they just finished this. Jane knew from her connections with other LHJs that Yakima had a software package ready to go on immunizations, so Kittitas bought the software to create its report. Jane also relies on the WA-ASSESS listserv, colleagues within the Health Department and at other LHJs, and DOH staff to build her knowledge and skills in assessment: “I’m not shy about asking for help from the Assistant Health Officer, colleagues, Christie Spice [DOH Assessment Liaison], Nancy, etc.”

Nancy’s background is in health promotion. She came into the director position three years ago with a very strong regard for assessment and evaluation. She views assessment as “doing your homework.” Every time Nancy goes to the Board of Health, she brings assessment data to explain why she wants to do what she is proposing. According to Nancy, the Kittitas Board of Health views everything the department does outside of mandated responsibilities as a policy decision “so we need to do our homework before we go down that road.”

According to a BOHAC member, “Nancy comes from a very challenging political background, and she puts that experience to work on her job here. She doesn’t put ‘the answer’ forward, she asks the question. She empowers. She listens. She does make decisions, but she does her homework and builds relationships first.” Another member said, “Nancy understands the community and is not invested in being the community mouthpiece. She can do it, but she mostly supports her staff in doing it.”

BOHAC members have seen this leadership approach shift the perception of the health Department in the community. Health Department staff did not previously feel empowered or knowledgeable: “They were going out in the community and getting beat up.” Now they are proactively interacting with people and explaining what the Health Department can and cannot do – “then those people remember to bring that [Health Department] information to bear when it is helpful to clients.” BOHAC members said that, as a result, they have seen the Health Department become much more a part of the community in the community’s eyes and especially in the Board of Health’s eyes.

Spokane Regional Health District

The experience of the Spokane Regional Health District is testimony to the prominent role a Health Officer can play in community health assessment and to the importance of dedicated and enthusiastic assessment staff in working with internal and external partners. The District maintains both a strong internal focus on community health assessment and program improvement, as well as an active external presence.

Spokane Regional Health District has a unique structure among those LHJs visited. The Health Officer, Dr. Kim Thorburn, oversees the District, with the Administrator, Torney Smith, reporting to her. The Administrator directs community health assessment and administrative functions; the Health Officer supervises human resources, epidemiology, and the regional HIV/AIDS program. Together, they oversee all other public health programs. Assessment and epidemiology are located within one office. Assessment, which used to be funded through Local Capacity Development Funds, is now part of the indirect cost pool supportive of all the administrative functions under Torney's supervision.

The Assessment Center, with a staff of 2.5 FTEs, coordinates and performs the many internal and external assessment activities that take place. Lyndia Vold, Assessment/Epidemiology Center Manager, devotes .5 FTE to assessment activities. The District also employs two full-time epidemiologists who are responsible for much of the community health assessment work. Another unique characteristic of the District's assessment practice is that its epidemiologists are also adjunct professors. This provides them with direct connections to local colleges, as well as access to online academic journals, that the District would not otherwise have. They are often called upon to provide training and technical assistance because of their specific expertise.

Following the example of her predecessor who exhibited a commitment to community health assessment, "Dr. Kim" is a driving force behind the District's assessment work. She has been the impetus behind various assessment projects, such as a study and community forums addressing unintended pregnancy prevention. She is an active participant in Board of Health meetings. She responds authoritatively to questions and has enhanced the Board's understanding of the expertise and excellence that District staff offer. Torney Smith also brings energy to the District's community health assessment work, as he was responsible for the District's community health assessment efforts in his previous role and, therefore, views assessment as a critical agency function.

Assessment staff market themselves as a resource for LHJ programs and community efforts to better understand health needs and mobilize services to address them. Internal and external stakeholders frequently noted the enthusiasm and energy assessment staff bring to their work. Since the mid-1990s, the District has built a community constituency for its work. Staff are invited to participate in community processes. Sometimes the District initiates involvement; sometimes staff are brought into existing processes. The result has been the enhanced visibility of the Health District in the community and an improved community understanding of public health.

The work of the assessment staff over the years has also generated what qualifies as no less than a hunger for data. Community stakeholders involved in the site visits spoke passionately about data and how it can benefit their work, whether through program

planning or grant writing. Several community members insisted that one can never have enough data and that data is needed at the neighborhood level to empower community work to make real differences in community health. Community members appreciate the thoughtful and creative manner in which assessment staff approach their work. The staff have assisted community stakeholders in getting, understanding, using, and presenting data and have increased community awareness of how much data the District can provide.

There is currently interest in establishing an online data warehouse that the District and community groups could post to in order to expand the availability of local data. Given the community's enthusiasm for data, it is not surprising that community members encourage the District to be even more active in publicizing what it has to offer and helping community members to increasingly access more and better data to support their community work.

Internal LHJ staff call upon their assessment colleagues for assistance with great regularity. LHJ staff recognize that programs need to be data-driven, including those that are categorically funded. Other LHJ staff engage assessment staff in ongoing discussions and frequently invite them to provide technical assistance in assessment-related activities. LHJ staff regard the assessment staff as internal consultants who can provide assistance in the development of data collection tools, data analysis, report writing, and data presentations. Assessment data has helped LHJ staff carry out program improvement efforts and target the grant requests they pursue, whereas they previously "chased after every funding opportunity that was out there." Staff view the enthusiasm and interest of assessment staff in their work as a key factor in their success. There is a sense of shared purpose, and the assessment staff provide them with a "fresh look" at the data.

A particularly noteworthy example of the internal use and impact of assessment data relates to a Teen Safe Driving initiative sponsored through the District's injury prevention program. Through the collaborative work of assessment and program staff, the program was able to get local police involved in data collection efforts around teen driving practices. The process was described as a "hard sell" with police officers who were hesitant to "fill out another form." Yet not only did police participate in data collection, they changed their own practices with regard to teen driving monitoring activities, based on the data collected. Whereas they had staked out certain local areas where they believed unsafe teen driving habits might be exhibited, e.g., where underage drinking might be occurring, they changed their targeted areas when data demonstrated that they could be more effective elsewhere. Not only did the LHJ program use the assessment data, but the police department also gained an appreciation for the value of assessment data.

The Health District has completed numerous studies to inform community and internal program and policy decision-making. Reports are published in both print and CD versions, with an increasing reliance on CDs, because they are less expensive. Information is also disseminated via the District's website, fact sheets, mailing lists to community members by topical area, presentations, press releases, and TV and radio interviews. The goal is to get and keep information in front of the public. The District also publishes a bi-weekly newsletter to provide LHJ staff with departmental information.

Thurston County Public Health and Social Services Department

The key theme from the Thurston LHJ site visit is “attitude is everything.” The Department’s internal and external community health assessment work is driven by a “can do” attitude that derives from the leadership of the LHJ director, Sherri McDonald, and key assessment staff member, Mary Ann O’Garro. Assessment is considered to be “the cornerstone of public health.” It is viewed as a function that needs to be integrated throughout the agency and the community, as opposed to an individual role. Assessment is also believed to be motivational – in a public health world where long-term outcomes are the norm, assessment enables staff and stakeholders to see the short-term impacts of their work through program and policy decision-making. The vision is broader than the internal needs of the Health Department; it is a community vision.

When working with the community, the LHJ director and key assessment staff consider the Department to be a community partner that works collaboratively and that emphasizes the importance of viewing, understanding, and using data as a learning experience. The attitude is “How can we do this together?” as opposed to “How can we do this for you?” They seek ways to “help in any way they [community members] let you” and aim to “turn scientific method into a community process.” After one experience in which a community group came to Department staff for assistance in analyzing data that had been collected through a flawed methodology, the Department conveyed an attitude of “we’ll do our best to help you make sense of what you have.” Then staff went one step further and advised their community partners that Department staff are available to assist in the early stages of research design and data collection to ensure better quality data.

The structure of the Thurston County Public Health and Social Services Department is such that no “filter” exists to reduce the communication between the LHJ director and the key assessment staff person. Assessment staff consider this structure to be an advantage in that the director has a greater understanding of public health data and assessment capacity.

Despite recent budget cuts, assessment continues to be valued as a core agency function. Currently, Thurston LHJ commits 1 FTE to community health assessment activities. Funding for assessment comes from contracts with community agencies, a Preventive Health Block Grant, Medicaid administrative match funds, and the county general fund. As budget cuts occur, the percentage of funds allocated to assessment has increased respectively. In budget requests to the Board of Health, assessment is not included as a line item; funding for assessment is at the discretion of the Department.

Mary Ann O’Garro and her predecessor Jeannie Knight have taken an active role in “marketing” assessment within the agency. According to other LHJ staff, assessment has yet to be “institutionalized” within the Department; the vision is that assessment will be integrated across the Department, but this has yet to be fully achieved. Program staff conduct assessment activities on an ongoing basis, but they do not necessarily define their activities as assessment and may not benefit from the assessment staff’s expertise. The assessment staff hope to become more of a resource to program staff over time.

Assessment data has been used internally to change Department practice. For example, the WIC program approached the assessment staff to develop a random survey of behaviors and values of parents when faced with data relating to a high rate of baby bottle tooth decay syndrome in Thurston County. A dental hygienist conducted exams, and the Department implemented parent education efforts. The environmental health program conducted a water quality assessment of well water. Based upon the results, the program applied for and received a grant to do education and additional monitoring. Environmental health staff got community groups involved in the process, which was a new approach for the environmental health program.

Mary Ann and Jeannie have done much to create an “open door” policy for technical assistance, both within the Department and with external partners. Much of this work is about relationship building – marketing the data and the department’s assessment services, passing along data reports and other information, and providing technical assistance, such as assisting other LHI staff with making presentations to the Board of Health or helping internal staff and external partners to better frame research questions and data requests. To help constituents frame their data questions, the Department distributes a handout entitled “10 Questions to Ask About Data.” The goal is to help “bring the data to life,” putting words to the numbers and helping people better understand what the data mean. Mary Ann also tracks data, document, and technical assistance requests, including what the request was, who requested what, what information or service was provided, and what the outcome of the request was, e.g., a community group received a grant, an LHI staff member made a presentation..

As a result of the Department’s community mobilization efforts, the Health Department is increasingly invited to the table as a community partner and is recognized as a resource for getting, using, and understanding data. The Department is seen as a “credible expert,” an objective community leader that is able to facilitate work on a broad range of health issues. The vision and commitment of the Department has kept community partners at the table. They know that their time will not be wasted.

The Department has benefited from the fact that community health assessment work and community mobilization efforts began early and that collaboration is a way of doing business in Thurston County. The vision and commitment of the Department to work with community partners around community health assessment began with Sherri McDonald’s predecessor, Pat Libby. Through the Board of Health, he initiated a Community Health Task Force in 1994 to establish a data-driven, community-driven assessment process. The Task Force started out with 25 community members, and through the enthusiasm and good work generated, expanded to 50 members over a one-year process.

As a result of the Task Force’s work, an initially skeptical Board of Health bought into the resulting “Strategies for a Healthy Future.” The Task Force spun off strategies generated through the process to the community. The Task Force has continued to meet periodically to take on specific issues, such as access to care and home visitation. The membership of the group has remained fairly stable, with additional expertise brought in as needed. The members are appointed by the Board of Health, so the Board of Health remains engaged in the work being done.

The Department benefits from a supportive Board of Health composed of three county commissioners. The Board takes a broad perspective regarding public health, including environmental health. The Department's community health assessment work benefits from the fact that one of the current county commissioners was a member of the original Community Health Task Force. The Board meets twice a month, so the Department has a great deal of "face time" with members. Still, when making presentations to the Board of Health, presentations are carefully framed around five questions:

- Why are we doing this?
- What is it going to cost?
- Where is the money coming from?
- Who will be doing this?
- What will they not be doing?

The purpose of the presentations is to describe the work of the Department and educate the Board about what data the Department collects and how it is used.

Cross-Site Findings

Each of the LHJs that participated in a site visit implements community health assessment in a way that is tailored to its own community. This customization contributes greatly to the success these LHJs are achieving in educating and mobilizing their communities to address a broad range of public health issues.

At the same time, there are a number of key similarities that emerge from these individual sites. These characteristics appear to be critical in making community health assessment practice an effective method of achieving the LHJ's goals.

Keys to Success

There is no one *right* way to conduct community health assessment

Leadership and vision are essential

The community is a powerful partner in achieving health goals

Dedicated staffing (and staff) make a big difference

LHJs committed to assessment find a way to make it happen

Access to key supports, e.g., timely data, technology, peer learning

Community Health Assessment Approaches Vary

Each of the LHJs visited has developed its own vision regarding the purpose of assessment, its relationship to the LHJ's mission, and where best to invest its resources to achieve its goals. These differences highlight the importance of customizing community health assessment to meet each LHJ's specific needs and priorities. The approach to implementing assessment is so related to the approach the LHJ takes in its work overall that it becomes a reflection of the leadership, values, norms, and practices of the organization and the communities it serves.

The demonstration of this customization through the site visits reinforces the idea that there are no correct methods to implementing community health assessment; the methods that are correct are those that successfully engage the community and produce changes in policies and programs and, ultimately, improvements in health status.

While there is a great deal of diversity in the approach the LHJs take in implementing community health assessment, there are a number of similarities that seem essential to their success.

Leadership is Strong

Key Findings

LHJ directors have an expansive vision of public health and the role of the community in achieving it.

Directors view assessment as a core function.

The health officer is engaged in the assessment function.

The Board of Health makes an important contribution.

VISION IS ESSENTIAL

The directors of the LHJs that participated in the site visits have a vision for public health and their organization's role in achieving it that goes far beyond the implementation of historical categorical programs. These directors' approach embraces a wide variety of *upstream* factors that have the capacity to bring about positive changes in the community's health. They are willing to engage the community around issues that are on the public's mind and build an informed constituency from there.

"Effectiveness requires going beyond the traditional public health indicators. You have to find the indicators that engage the public and elected officials, such as family violence, drugs, and alcohol."

In addition, these leaders believe public health can effectively work to inform and learn from other sectors of local government. Public health staff bring information about public health and its methods to other departments within the local government, including the county manager, the planning department, and the police department. They also understand how to take advantage of enlightened self interest to engage these departments. These LHJs work within their counties to integrate health assessment data into priority setting at the county level and to get public health issues on the table as issues that need to be addressed through multiple avenues.

"Before public health can become a community priority, it has to be local government priority."

Practice Idea

One of the directors of the LHJs serves as public health's emissary to the other parts of local government. She asked the other departments in county government and the local hospital what sections of the BRFSS they wanted the LHJ to carry out; the BRFSS served as a focusing event for a lot of data interests (and also reinforced the LHJ's role as a helpful provider of accurate information to multiple sectors of the government and community).

Directors advocate for local governmental priorities that reflect public health trends and are often active participants in addressing community issues relating to poverty, criminal justice, behavioral health, and access to medical care. They have a broad view of who their constituents are and work on building support for public health.

ASSESSMENT IS TRULY A CORE FUNCTION

The LHJs that participated in the site visits have placed community health assessment at the heart of their organizations. They integrate the collection and analysis of data, as well as the involvement of the community, into many of their LHJs' efforts. Assessment results are used in setting public health and community priorities, providing accountability in matching priorities to needs, and generating additional resources to address key LHJ and community needs. These LHJs are striving to bring evidence-based decision-making to their organizations and communities.

"Assessment is a tool to bring people together to set priorities and take unified action based on science."

In addition, they are modeling the role data can play in generating additional resources to support LHJ and community programs. The successes these LHJs can attribute to their ability to document and understand public health issues is helping them to build both internal and external constituencies for assessment practice as an essential LHJ function.

"Assessment is a catalyst to generate broader responses to community health issues."

THE HEALTH OFFICER PLAYS AN IMPORTANT ROLE

The health officer's role in community health assessment varied among the six sites visited. In some sites, the health officer played a vital role. In those LHJs where the health officer and the director shared a vision for public health and community health assessment, the LHJs had additional strength. These LHJs were able to bring the health officer's credibility and expertise to the issues the LHJs was facing – within the health department/district, within the local government, and throughout the broader community.

“The health officer can verify the truth of what the LHJ is saying about the importance or severity of a particular health issue. The health officer can help the local Board of Health understand the difference between real knowledge (what the data say) and testimony (what the public thinks is going on).”

LHJ health officer staffing varied among the sites visited. Two of the sites had full-time health officers (in one of these sites, the same person serves as the director and the health officer), and four employed the health officer part-time.

THE BOARD OF HEALTH IS ENGAGED AND SUPPORTIVE

As with many of the factors that comprise each LHJ’s approach to community health assessment, the characteristics of the Board of Health varied considerably in size, composition, and breadth of their role:

Board of Health composition

- A seven-member board with four community members and three county commissioners (Jefferson)
- A five-member board with three county commissioners and two community members (one M.D. and one M.P.H.) (Kittitas, Island)
- A three-person board made up of the three county commissioners (Thurston)
- An 11-member board – three county commissioners, three city council members, two elected officials from other jurisdictions within the county, and three at-large members approved by the board (Spokane)
- A nine-member board with the mayor of each city in the county (Bainbridge, Poulsbo, Bremerton, Port Orchard), three county commissioners, and one councilmember each from Bainbridge and Bremerton (Kitsap)

Regardless of the board’s size and composition, these LHJs were clear that it was essential to develop the board into an entity that helps the LHJ address health issues. Each LHJ involved in the site visits reported that it has a Board of Health that provides political, financial, and policy support. Generating this kind of support has generally been the direct result of LHJ efforts through community mobilization work.

Creating an engaged and supportive board is part of the director and assessment staff’s vision for addressing a broad set of public health issues. They reported spending a significant amount of time educating and involving the board and building the board’s trust in them. The LHJs invest a great deal of energy in building their Board of Health’s capacity. The LHJ directors and assessment staff make assessment-related presentations to the board on a regular basis. They understand the importance of educating the board about the importance of data-driven decision-making and program design.

“The goal is to shift the Board of Health’s priority setting from perceived needs to evidence-based needs. They have to spend enough time working on public health issues to become educated and engaged.”

One LHJ’s essentials for board development are:

- Persistence – keep bringing the information to them, e.g., BRFSS results
- Involvement – include board members in projects that will expand their understanding of health issues, e.g., reproductive health
- Recruitment – have board members willing to serve as champions on issues, e.g., tobacco, obesity
- Education – demonstrate the importance of expertise and evidence-based approaches

Practice Ideas

The Thurston Board of Health meets twice a month for an hour and a half. These meetings focus on broad public health perspectives. The LHJ staff also make presentations to the Board outside their regular meeting time.

The management team spends time at its meetings developing topical and programmatic presentations for the Board of Health. The focus is on what they do, why they do it, how many people are involved in it, and how many people are affected.

The Kitsap LHJ highlighted a transition it will be making with its Board of Health:

The Board of Health reviews the assessment data every year and picks priority issues; the current focus is on leading causes of death. During the next round of priority setting, the Health District will shift to a burden of disease approach.

The Community is a Powerful Partner

The LHJ director and assessment staff at these sites view the community as a critical player in improving health status and use community health assessment as a vehicle to engage and mobilize the community around health issues. They view the role of assessment staff as providing the LHJ and the community with the information necessary to prioritize and address a broad range of public health-related issues. These LHJs enlist the community in understanding health, setting priorities, galvanizing resources, and assessing success/failure. They view broad and meaningful community involvement as an essential asset in improving

public health. They encourage participation by any and all stakeholders and treat them as peers with much to contribute.

"This is not a work plan for the health department; this is a work plan for the community."

"Assessment takes issues local people know are problems, such as oral health, and turns them into projects that can get community support and resources. Our BRFSS data indicated that 45 percent of our population doesn't have dental insurance – it validated people's concerns and encouraged them to do something about it."

"Partnerships among community organizations are the key. The hospital uses the Health District's data for strategic planning and contributes funding to some of the priorities identified through the Health District's assessment work. We've also worked on issues together – like youth suicide."

It is clear that the development of a shared vision for community health through meaningful community involvement is a cornerstone for these LHJs. They share power with the community and assist it in identifying the health issues to address. These LHJs serve as the technical expert and view the community as their customers.

"One of our key roles in working with the community is to help them understand what different data mean – to teach them how to think about the data and draw appropriate conclusions. The BRFSS is key – it provides us and the community stakeholders with a manageable amount of information about what's impacting the community and provides ideas for priority areas to address."

"What you're doing is sales, not science. LHJ leadership plays an important role in helping the LHJ staff, community, and agencies adopt science-based approaches, not just popular ones."

The LHJ directors and assessment staff stress that it is essential that the LHJ director and assessment staff understand the community norms about how to approach problems and issues. This includes considering how different words or different ways of speaking about issues resonate with particular communities. Denial is also a big problem in many

communities where health indicators are poor. It is critical to invite a broad audience to hear what the data say and to present the information over and over again, giving people a chance to let it sink in.

"You have to present the community with a picture people can cope with – asset approaches do this. We don't use the term 'problems' in our community discussions, we use 'strategic issues.'"

The LHJ directors and assessment staff believe in partnerships as a way to accomplish public health goals; they form partnerships with hospitals, schools, and social service agencies to bring assessment data to the table and make it useful. They help other community agencies do a better job of assessment and make use of the results to change programs and policies.

These LHJs are clear that one critical role of assessment is to bring additional resources into the community. The LHJ directors market assessment and the associated knowledge it brings by stressing its value as a source of new revenues for the community. The LHJs make data available to help others write grants that bring in funds to address issues. The LHJs are connected to community agencies to make sure their resource development efforts do not overlap.

"Good assessment data has given our community an edge in bringing in grant resources. We've worked together with community agencies to bring in \$250,000."

STAKEHOLDER GROUPS ARE STRONG

Five of the six LHJs visited have a community-based stakeholder group of some kind; this group is invested in public health issues and brings an additional, and separate, voice to local public health issues. Again, the size, structure, and composition of these groups vary – the key is that the LHJ has an active voice in addition to its own. Examples of site visit stakeholder group composition include:

- A 21-member community health advisory board that "acts as a voice of the people and advises the Board of Health directly, not through the health department." (Island)
- A new 26-member environmental health advisory board will play a role similar to the community health advisory board (Island)
- An Advisory Committee that has evolved into a non-profit organization that "provides an independent voice for public health" (Kittitas)
- A Data Steering Subcommittee interested in using data for fact finding, planning, and grant writing (Jefferson)
- A Data Cleaning Subcommittee that works together to make sure the data in use is correct (Jefferson)

- A Community Health Task Force that helps the LHJ develop strategies to address priority issues (Thurston)
- Issue-based assessment coalitions that work on different public health issues, e.g., asthma (Spokane)

"We're not an arm of the Health Department; we're here to look at the health of Island County." -- An Island County Community Health Advisory Board member

Practice Ideas

Island County Community Health Advisory Board Roles:

It identifies priority issues, action plans, and recommendations to forward to the Board of Health for review, approval, and implementation (through the LHJ or other parts of county government).

It works to find solutions on problems that are stalled, e.g., there was no money to conduct the BRFSS – the CHAB worked with the hospital to allocate funds to conduct it.

It serves as a link to provide incoming information for the LHJ and to distribute health-related information to the community; they form a two-way bridge.

CHAB Members Identified Their Keys to Success as:

Bringing together a diverse collection of community members (geographic, income, diversity of expertise, impassioned people, leadership skills, student representatives)

Excellent and attentive staffing (agendas, minutes, information, staff support to action teams, provision of models to inform their work)

Members feel invested in and committed to the process – they believe their role in the community is recognized through CHAB, they believe that they are doing important and needed work, and they believe they are in a position to make a difference

Kittitas Board of Health Advisory Committee:

The Kittitas Health Department started an advisory group during the first APEX process in 1991. The Advisory Committee assisted in the restructuring of the Board of Health to add the two community members. They also transitioned to an independent private non-profit organization.

Practice Ideas (continued)

The committee currently provides a high profile group that can “get in the commissioners face” on public health issues. The Committee members have jobs to do on the group – phone calls and assigned tasks. Their work is taken seriously. They have power and responsibility.

The Committee’s advice for other LHJs – “Find people who are connected to health care in some way and who are interested in community service and give them real work to do and the power to do it. ”

Community stakeholder groups can advocate for public health improvements that may be politically tricky for the LHJ to push, e.g., a needle exchange, or programs that are more prevention focused than LHJs can financially support, e.g., a walking program. They can also assist the LHJ in obtaining additional local funding, e.g., studying the adequacy of funding for LHJ and considering funding options such as the legislature’s granting counties the authority to raise the sales tax by \$.02 to support public health.

Practice Ideas

What keeps Advisory Committee members involved?

The LHJ director’s (and perhaps the health officer’s) involvement

Dedication and quality of staff working with them

Improved understanding of how public health and county systems work

Ability to have an impact

Opportunity to look at broad issues

Being part of a group where everyone’s committed

Having real work to do

The LHJs report that one key to mobilizing effective stakeholder groups is to combine community volunteers with passion and paid staff with passion. This leads to mutual respect that enables the stakeholder groups to get involved in important issues. The ability of the LHJ to assign dedicated staff to community stakeholder groups also makes a big difference. The LHJs visited have built this assignment into the job of assessment staff and recognize that community involvement is time consuming. The strongest stakeholder groups have:

- Members with a personal or professional interest in public health (passion)
- The ability to have an impact (power)
- Real work to do (purpose)

The LHJs that participated in the site visits viewed teaching community agencies the value of data-driven decision-making as one of their key responsibilities. The LHJs serve as advisors to community groups and agencies conducting assessments, provide individual technical assistance, and offer encouragement to programs interested in learning how to collect and analyze data. As a LHJ staff person mentioned at one site, attitude is everything.

"It's critical that health department staff take a positive approach with community groups that are working with data. Give positive feedback and advice for next time; don't say their data is terrible. You're helping people learn over time."

A critical aspect of this commitment on the part of LHJs is an interest in changing agency norms about the importance of evidence-based decision-making. The agencies' success in garnering additional grant resources based on their ability to clearly describe needs serves as an important reinforcement.

"Community groups that started using data six or seven years ago are still using it."

Staffing and Structure Make a Big Difference

Keys to Success

Assessment is a dedicated staff function.

Assessment staff have direct access to the LHJ director.

Staff conducting assessment have passion for it.

Staff development and training are available.

All of the LHJs that participated in the site visits have dedicated assessment staff, ranging from one LHJ with .5 FTE assessment staff to another with 2.5 FTEs. LHJs reported that the key is that each of these individuals' time was dedicated to carrying out assessment activities.

"Dedicated assessment capacity must be available somewhere – if you can't pay for it, partner for it"

The LHJs have structured the placement and reporting relationships for assessment in a variety of ways. However, two similar characteristics stand out: the LHJ director is engaged in assessment, and the lead assessment staff reports to the director. The assessment staff's reporting relationship to the director adds two strengths to this role:

- It sends a strong message regarding the importance of assessment within the LHJ
- It encourages regular assessment staff input in policy decisions at the director, Board of Health, and community levels

In addition, the LHJ director's ability and willingness to articulate the assessment function to the program staff, reinforce program staff use of assessment, and encourage the staff's involvement in external assessment activities are extremely important. The director sometimes serves as the broker between the LHJ's programs and the assessment staff by enforcing assessment staff priorities, controlling how much they can take on, involving them in programs that need assessment help, etc.

In examining the expertise required to conduct assessment work, the directors and staff reported that a formal research background is not essential. They stressed the following as the most important skills that assessment staff can either bring with them to the job or develop on the job:

- Epidemiology
- Data collection and analysis
- Report development
- Communications
- Participatory leadership, including collaborative problem solving
- Collaborative approaches

The LHJs have developed their assessment capacity in a variety of ways. One LHJ started without any assigned staff trained in working with data. The director brought an internal team together to work with an outside consultant with knowledge of epidemiology – the current assessment person is the staff member who got interested in data and wanted to get more training and take on that role.

The staff working on assessment also use creative methods to make their funding stretch and make the best use of their time. For example, one LHJ contracts out the raw data for analysis and then writes the reports and fact sheets based on the results. Assessment staff also get help from other LHJs who have additional expertise in a particular topic, e.g., how to make user-friendly handouts, advice on conducting the Healthy Youth Survey, etc.

The LHJs have been creative in building a team with the skills they need through staff, contractors, and assistance from DOH and other LHJs. They use a combination of staff and outside resources to perform assessment activities. For example, some have an epidemiologist on staff. Some contract out for epidemiology. Some have LHJ staff currently involved in training, and some have learned on the job and through DOH trainings.

ASSESSMENT STAFF VIEW THEMSELVES AS RESOURCES

All of the LHJs visited have staff working on assessment who are excited about the capacity it offers to address community health issues. These staff have a diverse array of ideas about how they can help LHJ programs, other local governments, schools, United Ways, hospitals,

and community agencies collect and analyze data to improve their programs and to generate additional funding for the community.

"The assessment staff must see him or herself as a resource to staff of internal and external programs."

"We'd like to create a Countywide Data Users Group to provide peer-to-peer support on access and technical assistance on different types of data. We'd invite health department staff, the hospitals, non-profits, etc."

These assessment staff have an "open door policy" for internal and external programs that need technical assistance on assessment issues or who make data requests. They publicize what they can do to help internal staff and external partners improve their programs and actively position themselves as a resource for program improvement. They recognize that they are working to change norms within the community and within their own organization.

"It takes time to be seen as a resource."

Practice Ideas

To encourage health department/district staff to use assessment:

Send out data alerts describing the new data or analyses that staff can look forward to seeing

Regularly offer to help programs design surveys and analyze the results

Show staff ways to use data to make good decisions

Be patient – it takes time to be seen as a resource

Often assessment staff create work teams that draw in staff from multiple parts of the health department/district - front office staff, nurses from involved programs, etc. They provide clear examples of how assessment has helped programs improve and explain what assessment is and what it helps programs do (including bringing in resources).

The role of assessment staff in the community is also very active. They make presentations, write reports, create mailing lists, send out information on a regular basis, post information on their website, prepare press releases, conduct radio and TV interviews, and distribute copies of easy-to-read fact sheets.

Practice Ideas

Assessment staff at one LHJ has a weekly show on both the local radio stations – one show is an hour long, the other 15 minutes. The show discusses local health issues and events; the assessment staff person organizes the show. The assessment staff person also coordinates a newspaper column focused on health issues.

Several LHJs put data on the web so it is available to health department/district programs, community agencies, and other parts of local government. They work hard to make it easy for community agencies to get help with data.

One LHJ estimates that about 20 percent of its assessment staff's time goes to stakeholder projects, like helping non-profits put together evaluation components for grant applications, being on panels, responding to specific data requests, and making presentations regarding health issues.

"You're trying to build community demand for assessment data - you have to create streamlined methods to distribute the information."

LHJs report that the use of assessment by their own programs is strongest when:

- Directors articulate the vision for assessment
- Assessment staff regularly interact with the management team
- Managers reinforce program staff use of assessment
- Assessment staff give priority to internal data requests
- Assessment staff are involved in program planning/improvement

One of the challenges facing assessment staff in these LHJs is that they are generating more demand for their services as they succeed in convincing community and LHJ programs to move to evidence-based approaches. This is taxing their capacity and their ability to give the community and the LHJ programs (their customers) what they need.

Paying for Assessment Takes Creativity and Commitment

Keys to Success

Directors who value assessment find a way to pay for it.

LHJs move beyond traditional funding streams to pay for assessment.

Assessment weathers budget reductions.

Each of the LHJs visited has developed a method of paying for community health assessment. They have transitioned assessment from a mandated and state-funded activity to one that requires the identification of resources to continue and competes with other LHJ activities for support. While these LHJs are succeeding in garnering funds to support assessment, some believe the state should return to explicitly supporting it.

"Assessment is not a priority for the state – if it is, they should step up to the plate and fund it. We may have to cut programs to grow our assessment capacity."

The LHJs have been creative and assertive in their pursuit of funding to pay for assessment. The current funding sources employed by the LHJs vary quite a bit and include:

- Local Capacity Development Funds
- Grants
- Contracts
- Indirect/administrative charge to LHJ programs
- Inclusion of public health in the countywide administrative cost pool
- Annual general fund allocations from local governments
- Medicaid fees
- Fees for assessment projects conducted for outside organizations
- Bioterrorism funding to build infrastructure and expand IT/assessment capacity

Practice Ideas

Sample of funding approaches from the site visits:

One LHJ has obtained a commitment from a city for \$25,000 per year specifically for assessment activities.

Another LHJ allocates 10 percent of its annual general fund allocation to assessment.

A LHJ with a strong interest in environmental health-related community health assessment has obtained funding from the Centers for Disease Control to implement the PACE EH model.

More than one LHJ is using Medicaid Administrative match to support assessment projects related to access to care.

LHJs have included assessment costs in their in-house indirect cost pool, along with the director, the finance director, etc.; all LHJ programs contribute funds to support these costs.

At least one LHJ has been able to successfully argue that public health benefits the county as a whole and should be supported by all of the county's departments; this LHJ receives funds as part of the county's indirect cost pool. Another LHJ is currently conducting a cost study to determine whether a health district charge could be added to the county's indirect cost pool.

Local hospitals contribute to the costs of assessment projects, e.g., the BRFSS.

Some LHJs are using DOH grants, e.g., Oral Health.

One LHJ obtained Family Policy Council funds to support a Community Conference on Data and Assessment – over 100 people from business, non-profits, schools, and other groups will come together to learn about the issues affecting children and youth and to set priorities for action.

Several LHJs charge fees to community and government agencies for assessment work that is part of processes that originate outside the LHJ, e.g., community agencies that ask the LHJ to gather and analyze data for their strategic planning processes. The LHJs negotiate a scope of work and fee with the agency. One LHJ estimates it generates between \$5,000 and \$10,000 per year this way. Another LHJ charged a local school district \$5,000 to conduct a survey similar to the Healthy Youth Survey. The LHJ charges \$40 per hour on these projects.

The LHJs reported that the more work they have conducted around assessment, the more valuable they view it. They see that they have greater ability to set evidence-based priorities,

to engage community partners who will advocate for their programs, to successfully seek out grant funds to implement strategies in response to their assessment findings, and to partner with local agencies in data collection and analysis.

Particularly in times of budget reductions, LHJs must make a strong case to their staffs and communities about the importance of community health assessment in focusing their public health efforts and galvanizing the community to care. In tight budget times, indirect costs are under additional pressure. These LHJ directors have found ways to fund assessment, even if it means making cuts to programs, believing assessment to be a vital function that increases LHJ efficiency and effectiveness.

Internal LHJ Programs Could Use Assessment to Their Benefit

The role of community health assessment in working with internal LHJ programs varied among the sites visited. For some LHJs, community health assessment does not, by definition, focus internally but rather focuses on educating and mobilizing the community. For other LHJs, assessment principles and practices are applied more evenly internally and externally.

It seems clear that many historically categorical LHJ programs have the opportunity to begin making systematic use of community health assessment practices. These programs are in a position to learn to use data collection and analysis techniques and to look at their programs' results and make associated program improvements. In addition, many of the public health issues these programs address could benefit greatly from a community mobilization strategy that might bring more diverse partners to the table.

LHJs Need Support to Succeed

Keys to Success

Access to useful, timely data

Peer learning opportunities

Technological expertise, in such areas as statistical analysis and epidemiology, as well as enhancements, such as GIS capability and web design/posting

The LHJs participating in the site visits were clear that there are a number of types of assistance they require to successfully implement and sustain their community health assessment work. In many instances, this support constitutes resources that are essential for assessment staff to do their work in an efficient or effective way.

The issue of access to data that assessment staff can easily manipulate came up often in the site visits. LHJs reported using a great deal of their limited assessment time struggling with

data to get it in a form they can use it. A number of LHJs requested additional help from DOH in accessing data they can work with more easily, particularly data that is broken out at a sub-county level.

The LHJs strongly endorsed the opportunity to meet with their peers at the regional assessment meetings and encouraged the continued use of this practice. Those LHJs who view themselves as less sophisticated in their expertise reported deriving a great deal of benefit from making ongoing connections with staff from other LHJs who are farther along.

Many LHJs recognize the importance of effective communication approaches in sharing the results of their assessment work. They shared their interest in developing greater technological expertise, such as GIS capability and web design/posting, to assist them in communicating public health findings to the broader community.

Knowledge Dissemination and Utilization

Key Findings

Organizations need to have the adaptive capacity (i.e., internal and external factors in place to support change) to incorporate new knowledge into existing practice.

Effective knowledge dissemination requires a link between the information being disseminated, the needs, beliefs, experiences, and skills of the intended audience, and the dissemination approach or strategy.

Research points to considerations or factors disseminators of information can take into account to increase the effectiveness of knowledge dissemination efforts.

“Messengers” are critical – they need to be trusted, knowledgeable opinion leaders.

Literature reviews relating to the dissemination and utilization of “best practice” knowledge and/or information describe how dissemination processes work, identify the optimal organizational conditions needed to ensure that dissemination results in utilization, and recommend strategies to ensure effective dissemination.

When speaking of “best practices” – model approaches or recommended practices that are evidence-based – experts note that “what works” is highly dependent upon context and is situation-specific. In other words, what works in one situation or environment works, in part, as the result of the conditions present at the time of implementation. In many instances, replicating the exact circumstances or conditions that facilitated the development of a “best practice” is impractical, if not impossible.

Rather than “replication” of best practices, experts recommend that those seeking to disseminate such knowledge and information think in terms of “adaptation” and “translation.” Experts describe the incorporation of new information and knowledge into existing practice as a highly personal act. The user of the information or knowledge must believe that he/she can take what is made available and adapt it to make it his/her own. There is, of course, some point at which a best practice is so adapted or changed that it is no longer evidence-based. However, the literature delineates recommended organizational conditions and dissemination considerations and strategies to ensure that best practice information or knowledge is transferred and utilized in a way that maintains the integrity of the best practice. Following are key findings from the literature under review.

Building Adaptive Capacity

In order to integrate “best practice” into existing practice, organizations need to build their adaptive capacity. Adaptive capacity is dependent upon a range of internal and external conditions.

INTERNAL CONDITIONS

- Management commitment and leadership

Management must create an organizational culture that supports continuous organizational learning and adaptation. Organizational leaders must continually encourage staff to assess current practice, gather new information and knowledge gleaned from professional expertise, and consider changes in practice based upon new information and knowledge. This requires a willingness to support risk-taking, acknowledging that mistakes may be made along the way.
- Change or transition management processes

Management must provide staff with the support needed to successfully bring about change or adapt to transitions. This requires effective communication pathways, a willingness and ability to deal with resistance to change, and clearly defined roles in making change happen.
- Ability to recognize the benefits of sharing and/or acting on new information

Management and staff must be able to see how acting upon the new information will improve professional practice, make their jobs easier, increase available resources, etc.
- Existing knowledge base consistent with proposed adaptation

People build upon previous knowledge in acquiring new knowledge. If a proposed adaptation is premised upon information or knowledge that does not currently exist within an organization, the knowledge transfer will fail. Sufficient knowledge and skill levels are needed to incorporate new practices into existing practice.

EXTERNAL CONDITIONS

- Peer pressure and/or competition

Peer pressure or competition between peers to incorporate new information or knowledge into existing practice can be an effective motivator.
- Mandates

If change is mandated, with clear consequences for failing to respond to the mandate, change is generally more likely to occur.

- **Uncertainty**

Experts describe a bell-shaped relationship between uncertainty and innovation. If there is too much uncertainty, people are unlikely to change, reverting to existing practice and clinging to what is known. If there is no uncertainty, people perceive little reason to change. If there is some uncertainty, people are more likely to try something new, recognizing that the new knowledge or practice may be linked to organizational survival.

- **Source-recipient relationship**

The source-recipient relationship is a key factor in successful dissemination and utilization. People are more likely to respond to a source they trust, whom they view as knowledgeable, or whom they have successfully relied upon in the past. Experts note that the process of disseminating new information that is intended to guide changes in practice is most effective when it is based upon relationships, rather than simply making the information available. Personal relationships make it happen.

- **Benchmarks for measuring success**

Benchmarks are useful in maintaining momentum and enthusiasm for change by making measures of success incremental and visible to those involved in implementing the change.

Effective Dissemination Strategies

The manner in which information or knowledge is disseminated in large part determines whether it will be utilized. Considerations in framing a dissemination strategy include:

- **Focusing on a problem-solving vs. research-to-practice approach**

People are more likely to change practice when confronted directly with a problem that the new practice is likely to resolve. Simply stating that research suggests making a recommended change is unlikely to result in utilization of the new information or knowledge.

- **Employing multi-faceted and multi-layered approaches**

Dissemination strategies need to be tailored to the audience. A range of strategies should be considered, depending on content and audience. For a list of possible approaches for sharing information or shaping behavior, see the table below.

- **Including strategies or innovations that are high in “trialability” and “observability”**

Recipients need to be able to experiment with pieces of the information provided to assess its value. The information also needs to be presented in such a way that the results of small applications of the information are observable to the recipient. The recipient must be able to see short-term outcomes resulting from the application of the information.

- Providing timely information
Information is most likely to be utilized if it is readily available and accessible at the moment that it is needed.
- Building upon a shared language and vocabulary
The source and recipient of the information must have a common understanding of relevant terminology, jargon, or manners of speaking utilized within a field of practice.
- Building upon a common knowledge and skill base
There is a correlation between the degree to which new information is consistent with or builds upon a pre-existing knowledge and skill base and the integration of the information into existing practice.
- Ensuring that the information/knowledge is compatible with previous organizational experience and organizational identity
It is much easier to draw upon one's own organizational experience than to understand the experience of another. In attempting to integrate new information into existing practice, the information must be presented in a way that references or is consistent with previous organizational understanding. If a recipient views the best practice information as deriving from organizational experiences, identities, or conditions vastly different from his/her own, the information is less likely to be acted upon.
- Recognizing that organizational cultures and subcultures determine what is perceived as valuable knowledge
If an organizational culture is, for example, averse to risk taking or if mistakes result in disciplinary action, best practice information that is predicated upon risk taking is unlikely to be viewed as knowledge worth applying to organizational practice.
- Demonstrating the benefits of the information/knowledge when translated to practice
The benefit of acting upon the new information needs to be clearly articulated by the source and clearly recognized by the recipient.
- Providing ongoing support and personal intervention
An ongoing personal relationship between the source and the recipient is more likely to result in the utilization of new information or knowledge.
- Building trust
The recipient of the information or knowledge will be more likely to act upon the information if it comes from a trusted source.
- Building in enough time
Based on existing literature, one expert recommends that 12 percent of project time and resources be devoted to dissemination activities to ensure success.

The Message and the Messenger

Effective knowledge dissemination requires a link between:

- The product or knowledge being disseminated
- The needs, beliefs, experiences, and skills of the intended audience
- The dissemination approach or strategy

The relationship between these three factors is summarized in the following table. The table outlines optimal characteristics of the source-recipient relationship that facilitate utilization, as well as factors relating to the content of the “message” being delivered and the strategy or medium chosen to convey the message.

Identifying the messenger is critically important to a dissemination strategy. “Innovators” who are respected and take a lead in implementation are necessary in early phases of the process. A broader group of trusted “early adopters,” who are viewed as opinion leaders, are then needed to spread the word and encourage their peers to act upon the new information or knowledge.

There is consensus that the relationships involved in the dissemination process are a key factor to success. Changes in practice happen because of the people involved. Particularly when a dissemination strategy is aimed at changing behaviors, the personal touch is more likely to bring about success.

THE EFFECTIVENESS OF DIFFERENT MECHANISMS FOR SPREADING BEST PRACTICE⁴

Sharing Information			Shaping Behavior	
General Publications	Personal Invitations	Interactive Activities	Public Events	Face to Face
Flyers	Letters	Telephone	Meetings	One to one
Newsletters	Reports	Email	Visits	Mentoring
Videos	Postcards	Visits	Conferences	Secondment
Websites		Workshops	Road shows	Shadowing
Manuals		Seminars	Networks	Focus groups
Articles		CD ROMs	Fairs	
Guidelines		Websites		
CD ROM		Toolkits		
Posters		Distance learning		
Displays		Team learning		
		Learning sets		
		Modeling		

⁴ "The Effectiveness of Different Mechanisms for Spreading Best Practice," www.servicefirst.gov.uk/2000/guidance/bpresearch5.htm.

ELEMENTS AND ISSUES RELATED TO THE DISSEMINATION PROCESS⁵

Elements Of Dissemination	Issues In Effective Dissemination
Source	<ul style="list-style-type: none"> · Perceived competence · Credibility of experience · Credibility of motive · Sensitivity to user concerns · Relationship to other sources trusted by users · Orientation toward dissemination and knowledge use
Content	<ul style="list-style-type: none"> · Credibility of research and development methodology · Credibility of outcomes · Comprehensiveness of outcomes · Utility and relevance for users · Capacity to be described in terms understandable to users · Cost effectiveness · Research design and procedures · Relationship between outcomes and existing knowledge or products · Competing knowledge or products
Medium	<ul style="list-style-type: none"> · Physical capacity to reach intended users · Timeliness of access · Accessibility and ease of use, user friendliness · Flexibility · Reliability · Credibility · Cost effectiveness · Clarity and attractiveness of the information "package"

⁵ "A Review of the Literature on Dissemination and Knowledge Utilization," July 1996, www.ncddr.org/du/products/review/exhibit.html.

Elements Of Dissemination	Issues In Effective Dissemination
User	<ul style="list-style-type: none"> · Perceived relevance to own needs · User's readiness to change · Information sources trusted · Format and level of information needed · Level of contextual information needed · Dissemination media preferred · Capacity to use information or product (resources, skills, and support)

Recommendations

The recommendations developed by Clegg & Associates for the AIA Steering Committee include asset-building work at multiple levels. These recommendations provide the foundation for the AIA partnership to assist the LHJs and DOH in creating a statewide network of communities using assessment to plan actions for public health improvement.

The following recommendations describe *what* needs to take place to improve community health assessment practice throughout the state. The subsequent stage in this process, the development of a four-year work plan, will detail *how* the AIA partnership will translate these recommendations into specific strategies to improve the capacity of LHJs and DOH to successfully conduct community health assessment practice throughout the state. This work plan will be completed prior to the beginning of the second year of the CDC grant in October 2003.

Recommendation #1

Create a Stronger System at the LHJ and DOH Levels to Support Implementation of Community Health Assessment Practice

The addition of a strong community health assessment practice will help LHJs achieve the gains necessary to improve the health status of the local population. However, the implementation of an effective assessment practice requires a long-term commitment, as many of the assets necessary to effectively carry out this practice take time to develop. The nature of these assets at the LHJ and DOH levels is outlined below.

Develop critical assets at the LHJ level

For LHJs to successfully develop a community health assessment practice that can impact program and policy decision-making, they must develop a set of assets, including:

- Expertise among LHJ leadership in:
 - Articulating a vision for the role of assessment in achieving the LHJ's and the community's public health goals
 - Managing assessment in support of achieving the Standards for Public Health
 - Creating an internal environment that values data-driven decision-making
 - Building internal capacity to conduct assessment activities

- Working effectively with the Board of Health, local elected officials, and leaders of other health care institutions
- Forming and facilitating community stakeholder groups
- Providing leadership at the state level with DOH
- LHI capacity to conduct assessment in such a way that it:
 - Teaches LHI and community programs how to use data to better understand their clients' and community's needs
 - Provides technical assistance to internal and community programs that are interested in conducting assessment activities
 - Gathers, analyzes, and presents data to inform policy and program decisions
 - Encourages community involvement and action around public health issues by playing a leadership role in coalitions and partnerships
- Acceptance among LHI program staff of:
 - Why ongoing program improvement is essential in delivering high-quality services
 - How they can collect and analyze data in time-efficient ways
 - How to build data collection and analysis into their program operations
 - How to use the results from their data collection and analysis to garner additional funding to support their programs
- Support from the Board of Health to:
 - Place a high priority on public health as a local government responsibility
 - Invest local financial resources to achieve public health goals
 - Support the LHI's data-driven decision-making processes
 - Provide policy leadership around controversial issues
 - Advocate at the state level for strong local public health capacity
- Engagement by the community to:
 - Play a leadership role in improving local public health status
 - Know how to use data to set priorities and make decisions regarding related strategies
 - Advocate with local elected officials to build a strong LHI
 - Take on controversial issues, encouraging progress on public health goals in the community and in the LHI

Build complementary assets at the DOH level

The assets required at the DOH level are also critical to the ability of the LHJs and DOH to work together to create a strong statewide network of community health assessment capacity. The key assets at the state level include:

- Clarity of purpose around community health assessment, including:
 - Articulating a vision for community health assessment in achieving the public health standards and public health goals
 - Demonstrating the importance of assessment in implementing DOH programs
 - Setting the standard for data-driven policy and program decision-making
- Demonstration of the importance of data-driven policy and program decision-making by:
 - Making community health assessment an identifiable priority within DOH
 - Committing the resources to provide leadership in developing assessment capacity across the state
- Leadership in the integration of assessment functions across categorical programs within DOH and in the funding streams that go to LHJs by:
 - Identifying creative methods for using categorical resources to create unified assessment capacity at the LHJ level
 - Eliminating reporting requirements that encourage LHJ-level separation of assessment functions
- Organizational support to LHJs, including:
 - Assisting in the acquisition of the resources needed to help LHJs implement sustainable community health assessment practices
 - Committing DOH resources to support the LHJs' assessment capacity
 - Supporting leadership development for DOH and LHJ staff
- Technical support to LHJs by:
 - Providing an ongoing and systematic approach to training in all aspects of community health assessment practice
 - Making easy-to-use, quality data available
 - Organizing technical assistance in a way that is accessible

The four-year implementation phase for the AIA partnership offers an opportunity to make significant gains in strengthening each of these assets. The types of asset-building described here are not easy to accomplish – they require vision, commitment, financial resources, a willingness to change, and strong coordination between the LHJs and DOH. The environment in which this capacity building will take place poses its own challenges – fiscal, programmatic, and political. Nonetheless, the commitment of the individuals and systems involved offers encouragement that these changes can occur.

Forge a shared LHJ/DOH vision for the role of community health assessment in achieving the public health standards and public health goals

The current degree of funding uncertainty is inhibiting the LHJs' ability to build their community health assessment capacity. The transition of assessment from a mandated, funded LHJ activity to an unfunded activity has changed how many LHJs view its importance when allocating their discretionary funds. While many LHJs continue to build strong assessment capacity within the current funding strictures, the obstacle of funding uncertainty is a barrier that many LHJs are unable to surmount. Reducing the impact of funding uncertainty on the LHJs' ability to carry out community health assessment would deliver gains across the entire system. These gains would be seen through success in achieving the public health standards and improvements in programs and policies.

At present, there is no system-wide understanding of what community health assessment is nor how it contributes to the achievement of major public health initiatives throughout the state and within local communities. The AIA partnership, working with DOH leadership and the LHJ leaders, must produce a clearer and more unified vision. In addition, the partnership and DOH/LHJs need to find ways to make assessment possible for more LHJs. Several ideas for how to pursue this clearer and more unified vision include:

- Prioritizing DOH funding for implementation of community health assessment activities and development of related deliverables
- Assisting LHJs in obtaining public and private resources to implement community health assessment activities, e.g., CDC funding
- Identifying leaders in personal health and environmental health to help LHJ staff in these programs make effective use of community health assessment practices
- Strengthening the DOH/LHJ working relationship on community health assessment
- Implementing an Appreciative Inquiry process to identify the situations where DOH and LHJs work together most effectively on community health assessment, examining the factors that characterize these situations, and adding related practice improvements to the four-year work plan.

Improve DOH integration of the funding and reporting of assessment activities taking place in categorical programs with broader DOH and LHJ community health assessment efforts

The current implementation of categorically-funded programs like HIV/AIDS and Tobacco Prevention make the establishment of high-quality, cost-effective community health assessment practice more difficult for the LHJs. While resources are often set aside for assessment in these programs, the funding also comes with detailed requirements for what assessment activities will take place, what the programmatic priorities are (without reference to the results local assessment data might produce), separate data reporting systems, and other barriers. These categorical approaches contribute to disjointed and inefficiently

administered assessment efforts at the LHJ level. Possible approaches to improving this situation include:

- Enabling LHJs to maximize their use of the assessment funds available through categorical programs by providing greater flexibility in use of these funds, e.g., Tobacco Prevention, HIV/AIDS, bioterrorism
- Streamlining the reporting systems for categorical programs to reduce the number of different systems LHJs and DOH staff must use

Enhance the type and amount of assistance DOH provides to help LHJs build their capacity to conduct community health assessment

Many LHJs have made significant progress in developing the capacity required to successfully conduct community health assessment. It is essential that DOH continue to support the LHJs' work in this area, including the following current and future actions:

- Maintaining the Assessment Liaison and Vista Coordinator positions
- Providing a basic set of processed data at the sub-county level to help LHJs accomplish more with the limited time they have available to spend on assessment activities and to work more effectively with their local stakeholders
- Working with the LHJs to identify the types of data necessary to support more sophisticated assessment practices some organizations are conducting
- Providing timely technical assistance to LHJs in data collection and analysis
- Developing an online clearinghouse of innovative LHJ community health assessment approaches, epidemiological practices, and other resources for LHJ use, e.g., model job descriptions for assessment staff; model policies for tobacco prevention, injury prevention, etc.
- Creating a stronger connection between DOH epidemiology staff and LHJ staff working in assessment, including examining the option of pairing individual DOH staff as mentors with specific LHJs (could be geographic or by type of assistance LHJs need)
- Developing DOH technical assistance capacity to work with LHJs conducting community health assessment activities in environmental health, e.g., assistance conducting the EH BRFSS
- Organizing trainings and workshops at program-based personal health and environmental health meetings to engage staff at DOH and LHJ level in using assessment

The recommendations outlined above take a systems approach to building the community health assessment capacity throughout the state. This method identifies the key supports LHJs need to succeed and recommends the source of that support. In addition, it takes advantage of the CDC grant's opportunity to make far-reaching and long-lasting improvements in capacity at both the DOH and LHJ levels.

Recommendation #2

Help LHJs Build the Community Health Assessment Capacity Necessary to Achieve the Public Health Standards Related to “Understanding Health Issues”

The 35 LHJs are at different stages of development in their use of community health assessment as a tool in achieving the public health standards and strengthening community health. This recommendation offers a customized approach that each LHJ can employ to begin improving its community health assessment practice. This approach will ensure that the activities undertaken through the work plan provide useful guidance to all of the LHJs, regardless of where they are on the development continuum.

The groups discussed below represent the three phases of community health assessment capacity among the 35 LHJs. The actions laid out for each group reflect the approaches the LHJs in each group could use to improve their assessment practice. As part of the implementation process, the AIA partnership could create a self-evaluation tool to help each LHJ identify the group from which it would most benefit.

GROUP ONE

The LHJs in this group currently focus primarily on the implementation of categorical public health programs, e.g., Maternal and Child Health, HIV/AIDS, water quality, and are not performing many community health assessment activities. They may not have a capacity-building process underway that will lead to achievement of the *Understanding Health Issues* Standards.

The practice improvement focus for LHJs in Group One is on establishing the value of community health assessment as a means to achieving the public health standards and the LHJs' goals. A secondary focus is on the different methods for developing organizational capacity to conduct a sustainable community health assessment effort.

Provide LHJs with assistance in evaluating their current capacity to carry out community health assessment

- Develop and test a straightforward assessment tool for assessing current capacity
- Provide technical assistance in administering the tool and interpreting the results
- Work with LHJs to interpret the results of their standards baseline evaluation
- Assist individual LHJs in developing a plan to improve their community health assessment capacity

Demonstrate the value of community health assessment in achieving public health standards and individual LHJ goals

- Organize peer mentoring among LHJ directors
- Work with the Washington State Association of Local Public Health Officials (WSALPHO) to increase the focus on community health assessment as a valuable tool in achieving public health goals

Facilitate transition management processes for LHJs

- Offer LHJs technical assistance in leading change processes within their organizations; these processes will help the LHJs incorporate new approaches to their program and policy decision-making
- Assist LHJs in identifying the organizational changes necessary to support a stronger assessment capacity

Assist in the development of infrastructure necessary to support implementation of community health assessment

- Assess the LHJs' computer capacity in relation to assessment practice
- Assist in implementing and learning how to use Vista software

Facilitate development of assessment capacity among staff working in LHJ personal health and environmental health programs

- Provide personal health and environmental health staff with examples of how community health assessment can help them achieve their goals
- Offer information regarding community health assessment processes and how they would work for personal health and environmental health programs
- Assist the LHJs in selecting one community health assessment project to implement and provide technical assistance during its completion

Assist LHJs in identifying ways to dedicate a portion of one person's time to focus on community health assessment activities

- Organize peer mentoring for LHJ directors around allocation of funding to enable dedication of time for assessment
- Provide assistance in garnering additional resources to support dedicated staff time

Offer training opportunities that assist the LHJs in incorporating community health assessment approaches

- Initiate leadership development training for LHJ directors, including visioning, transition management, learning organizations, facilitating participatory community processes, creative financing, etc.
- Conduct leadership development trainings for Boards of Health, including public health goals and role of community health assessment in achieving them
- Provide data collection and analysis training for personal health and environmental health program staff
- Offer additional Vista training

Support professional development opportunities

- Increase the emphasis on assessment at LHJ and DOH leadership meetings
- Increase the participation of LHJ directors and staff in assessment-related trainings and conferences

GROUP TWO

These LHJs have added broader issue areas, e.g., domestic violence, to their public health focus. They see the value of community health assessment in better understanding health issues but do not see a way to go beyond some limited efforts due to lack of financial resources. As a result, they may conduct discrete community health assessment activities but do not have an ongoing mechanism for involving stakeholders in setting priorities and planning public health improvements.

The practice improvement focus for Group Two is on developing the organizational capacity, both in terms of finances and expertise, to develop and conduct a sustainable community health assessment effort.

Assist in the development of infrastructure necessary to support community health assessment capacity

- Investigate the implementation of regional health assessment capacity in geographic areas where interest in assessment is high but resources are insufficient
- Encourage development of assessment capacity through dedication of staff time (can be in very small amounts)
- Help the LHJ director identify a staff person who will be successful in learning how to do community health assessment (assuming there is no staff dedicated to this function now)
- Initiate training of LHJ managers and personal and environmental health program staff to enable them to broaden their community health assessment activities

- Provide peer mentoring to help LHJ staff do assessment work (at program and/or community levels)

Provide training to assist LHJs in building their skills

- Provide skills training related to conducting community health assessments, including technical skills for basic data collection and analysis
- Offer skills training for gathering, analyzing, and communicating data for policy and program decision-making
- Provide skills training for forming and facilitating collaborative processes, including methods for learning from other public health programs, such as health promotion
- Offer leadership training for LHJ managers to improve their understanding of community health assessment and its role in achieving public health goals

Support professional development opportunities

- Increase the emphasis on assessment at program-based meetings, e.g., trainings on data collection and analysis for policy and program decision-making
- Increase the emphasis on assessment at annual state meetings, e.g., annual environmental health meeting

GROUP THREE

The LHJs in Group Three are engaged in a variety of community-based initiatives around issues like water quality, parenting effectiveness, and violence prevention. They view community health assessment as a critical function in achieving the public health standards and attaining their LHJ's and community's goals. They have dedicated some amount of internal staff or consultant time to community health assessment and are active in seeking out additional assessment projects. These LHJs may have a strong community-based assessment focus and are interested in developing a stronger internal use of data to inform program design and decision-making.

Assist LHJs in evaluating the status of their current community health assessment practice

- Provide a tool LHJs can use to determine the appropriate next steps in improving their community health assessment practice (use site-specific baseline evaluation results, best practice, peer capacity, etc.)
- Provide ideas, resources, and advocacy to help these LHJs take the next steps
- Organize peer mentoring to help LHJ staff doing assessment work (at program and/or community levels)

Provide training opportunities

- Offer skills training related to forming and facilitating internal and external collaborations
- Provide skills training focused on data collection, analysis, and communication for program and policy decision-making
- Organize intermediate and advanced skills training on data analysis
- Offer skills training in teaching community agencies and LHJ personal health and environmental health programs how to collect and analyze data

Support professional development opportunities

- Increase the emphasis on data collection, analysis, and communication for program and policy decision making at program-based meetings and trainings
- Increase the emphasis at regional assessment meetings on managing transitions to data-driven decision-making (internally focused) and on facilitating collaborative processes
- Convene statewide peer learning workshops for LHJ staff working in assessment

The availability of customized practice improvement strategies offer each group of LHJs a chance to improve its practice, based on its starting place. This move away from a one-size-fits-all approach enables the LHJs to focus their practice improvement energy and make the most gains.

Recommendation #3

Make Community Health Assessment More Useful to Personal Health and Environmental Health Programs

Community health assessment practice is not contributing adequately to the achievement of personal health and environmental health goals. There are numerous benefits assessment could bring to these program areas, but this contribution has not yet been realized. LHJ leadership and staff involved in assessment have an opportunity to share the benefits of data-driven program and policy decision-making with these program areas. The willingness of assessment staff to reach out and encourage the participation of the staff in these program areas is critical in making this happen.

Develop a vision for the role of community health assessment in achieving the personal health-related standards and goals

- Convene a leadership-level work group made up of DOH staff and LHJ leaders to create a vision and implementation strategy for integrating community health assessment practice into these programs
- Identify DOH and LHJ leaders who can champion the importance of community health assessment in achieving personal health goals

Develop a vision for the role of the community health assessment in achieving environmental health-related standards goals

- Convene a leadership-level work group made up of DOH staff and LHJ leaders to create a vision and implementation strategy for integrating community health assessment practice into these programs
- Identify DOH and LHJ leaders who can champion the importance of community health assessment in achieving environmental health goals

Offer training opportunities

- Initiate customized leadership development training for DOH personal health and environmental health leadership, LHJ directors, and LHJ personal health and environmental health directors focused on visioning, transition management, learning organizations, and facilitating participatory community processes
- Conduct leadership development trainings for Boards of Health with a focus on personal health and environmental health goals and the role of community health assessment in achieving them
- Provide training in implementation of different methods to engage the community in environmental health issues, e.g., PACE EH

Professional development opportunities

- Ensure that training on community health assessment is available at state-level personal health and environmental health conferences

The integration of community health assessment practice into personal health and environmental health efforts is an important step in building the capacity of these programs to address LHJ and community needs. The ability to mobilize community members around these programs adds to the LHJs' strength in taking on the many difficult issues facing these program areas.

Appendix

AIA Evaluation of Community Health Assessment Practice

Phone Interview Guide — LHJs

Name of Interviewee:

LHJ:

Name of Interviewer:

Today's Date:

Hi _____, this is _____. As you know, I'm with Clegg & Associates, and we're working with the Assessment in Action Steering Committee. Our purpose is to understand how different LHJs conduct and support community health assessment (and how DOH supports it), with the goal of identifying strategies that will improve the effectiveness of assessment efforts across the public health system.

I know you recently participated in the Baseline Standards Evaluation; we are doing our best not to duplicate that work. (We do not have access to the results for individual LHJs).

Before we begin, do you have any questions about this interview or its purpose?

Do you have the Logic Model?

- 1. Looking at the AIA Community Health Assessment Logic Model and how it defines health assessment activities, please describe your current assessment capacity.**

Probes:

- **What assessment activities are currently underway?**
- **What would you like to be doing that you don't have the capacity for now?**

- 2. How has the assessment function evolved over time in your LHJ?**

Probes:

- **How were you able to complete the mandated assessments during the mid-1990s?**
- **Have you maintained that staffing/consultant?**
- **What are the main factors that have influenced the evolution of assessment in your LHJ since the mandated assessments?**

- 3. How is assessment structured within your LHJ — meaning, where does it fit within your organization and who does the work?**

Probes:

- Which staff participate in assessment activities?
- Do they have other responsibilities?
- What skills do they have which particularly benefit their assessment work?
- How does this structure/staffing model benefit the assessment work?
- What are the main challenges or problems with the way assessment is currently structured/staffed in your LHJ?

- 4. How do you fund your community health assessment activities? (e.g., LCDF, extramural, indirect charge to programs)**

Probes:

- How has funding of assessment evolved over time in your LHJ?
- In what ways have you been able to be creative/innovative in funding assessment activities?
- What do you foresee affecting future funding of assessment activities in your LHJ?

- 5. Who are the main constituencies (internal and external) for health assessment in your LHJ? (meaning -- who is interested in your assessment work?)**

Probes:

- How and when (at what stage) are community partners identified and involved in community assessment?
- Why is assessment important to them?
- How would you like to see constituencies for assessment strengthened and broadened in your LHJ?
- Are their particular constituencies you would like to reach?

- 6. What would you say are the most important impacts or changes that have resulted from assessment activities in your LHJ?**

Probes:

- Changes in awareness, attitudes, knowledge and skills?
- Changes in programs, policies, resources?
- Other changes or opportunities?

7. What obstacles get in the way of your LHJ carrying out its assessment practice?

Probes:

- Obstacles internal to your LHJ?
- Community obstacles?
- DOH obstacles?
- What would help your LHJ deal with these obstacles? (e.g., technical assistance in community involvement, increased access to data)

8. What resources are essential for your LHJ to undertake or maintain health assessment activities?

Probes:

- Internal LHJ resources?
- Community resources?
- DOH resources?

9. On a scale of 1-10 (1=not at all important; 10=mission critical), how important do you believe the assessment function is to your LHJ achieving its goals?

1	2	3	4	5	6	7	8	9	10
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Probes:

- Can you give me some examples of how assessment supports your agency's progress toward its goals?
- Without the assessment function, what do you think would be lost?

10. Is there anything else you'd like us to know about community health assessment practice in your LHJ?

11. We will be conducting site visits to 6 LHJs in the near future. This will involve a one-day site visit where we'll do individual and group interviews with a number of staff in the LHJ and some key stakeholders in the community. We'll be selecting sites of differing sizes, staffing and geographic location.

Would you be willing to serve as a case study site this spring, if selected?

☐ Yes

☐ No

**Thank you very much for taking the time to do this interview.
We appreciate it.**

AIA Evaluation of Community Health Assessment Practice Phone Interview Guide — Key Informants

Name of Interviewee: _____

Office/Unit: _____

Name of Interviewer: _____

Today's Date: _____

Hi _____, my name is _____, and I am with Clegg & Associates. Thank you very much for taking the time to speak with me today. As you know, we're working with the Assessment in Action Steering Committee. Our purpose is to understand how different LHJs conduct community health assessment and how DOH supports health assessment practice, with the goal of identifying strategies that will improve the effectiveness of assessment efforts across the public health system.

Before we begin, do you have any questions about this interview or its purpose?

1. What is your vision of community health assessment's potential for Washington State?

Probes:

- What would ideal implementation look like?
- What changes might result from it?
- How would LHJs benefit?
- How would DOH benefit?
- How would Washington residents benefit?

2. What roles do you think are most important for DOH to play in supporting community health assessment practice? (e.g., providing training and technical assistance)

Probes:

- What does DOH provide now?
- What do you think DOH should or could provide in addition?
- What resources could DOH access to support the work?

3. What obstacles get in the way of DOH playing its key roles in health assessment?

Probes:

- Internal DOH obstacles?
- LHJ obstacles?
- Other obstacles?

4. What roles do you think are most important for LHJs to play in carrying out community health assessment? (e.g., adapting data for local use)

Probes:

- What are LHJs doing now that is most important?
- What do you think LHJs should or could do in addition?
- What resources could LHJs access to support their work?

5. What obstacles get in the way of the LHJs conducting their health assessment work?

Probes:

- Internal LHJ obstacles?
- DOH obstacles?
- Other obstacles?

6. DOH and LHJs have distinct, but interrelated roles in assessment. For the assessment function to be carried out effectively, coordination between DOH and LHJs is often necessary.

From your perspective, how are DOH and LHJs working well together on assessment?

Probes:

- Strengths in coordination?
- Strengths in communication/sharing information?
- Strengths in resources/skills/abilities?

7. In what ways are DOH and LHJs not working well together on assessment?

Probes:

- Weaknesses in coordination?
- Weaknesses in communication or sharing information?
- Weaknesses in resources, skills, or abilities?

8. What do you believe are the best ways for LHJs and DOH to improve the strength of their “partnership” in assessment?

Probes:

- Improvements in coordination?
- Improvements in communication or sharing information?
- Improvements in resources, skills, or abilities?

9. On a scale of 1-10 (1=not at all important; 10=mission critical), how important do you believe the assessment function is to the LHJs achieving their goals?

1	2	3	4	5	6	7	8	9	10
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10. On a scale of 1-10 (1=not at all important; 10=mission critical), how important do you believe DOH's role in supporting community health assessment is to the DOH agency mission?

1	2	3	4	5	6	7	8	9	10
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11. Is there anything else you would like us to know about community health assessment practice at the state or local level?

**Thank you very much for taking the time to do this interview.
We appreciate it.**

Site Visit Protocol

Improving Community Health Assessment Practice

Assessment in Action Grant Year 1

Background

Clegg & Associates will be conducting site visits to six Local Health Jurisdictions (LHJs) as part of the Assessment in Action efforts to improve community health assessment practice. The purpose of the six site visits is to capture the methods these LHJs have used to make assessment a driving force in their organizations and communities. The site visits, in combination with the initial telephone interviews conducted with all LHJs and related follow-up, will provide the basic ingredients for the community health assessment improvement strategies the Assessment in Action (AIA) Partnership will develop for Years 2 through 5 of the CDC grant.

Site Selection

The AIA Steering Committee selected the following LHJs for site visits: Island, Jefferson, Kitsap, Kittitas, Spokane, and Thurston. The Committee's aim was to select a group of LHJs that would provide the most useful information for development of strategy recommendations for improving assessment practice. "Most useful" was defined as offering the most learning benefit for other LHJs (and for the public health system as a whole) to enhance the effectiveness and impact of our assessment work. Site visit criteria:

1. Evidence of a promising/model approach to community health assessment
2. Approach to assessment appears replicable within other LHJs
3. Approach to assessment appears sustainable over time
4. LHJ is facing/overcoming common obstacles to assessment
5. LHJ is willing to serve as a site visit for this study
6. Sites collectively represent the diversity of LHJs (in terms of size, structure, geographic location, etc.)

Site Visit Focus

In order to gather the information necessary to create the community health assessment improvement strategies, the site visits will focus on four areas:

- Obtaining a rich description of the sites in terms of the specific role assessment has played in achieving short- and longer-term impacts at the LHJ and broader community levels
- Identifying the factors that make assessment successful in these LHJs

- Understanding the pathways these LHJs have followed in achieving their successes
- Capturing the LHJs' insights into the strategies we could employ to make the knowledge gleaned from the site visits transferable to other LHJs and communities.

Site visits will include the following activities: A group discussion with the LHJ Director and assessment personnel, a focus group with other LHJ staff, discussions with Board of Health members, a focus group with stakeholder or community groups, and review of relevant documents. Site visits may include individual interviews with key personnel or stakeholders if appropriate.

Site Visit Discussion Guide

Each site will participate in discussions regarding a common set of questions as well as customized questions that address specific model approaches shared during the phone interview. The common questions for each site appear below, followed by site-specific questions for each LHJ.

We have developed a logic model (describing how the LHJ's assessment practice leads to action) for each of the sites using the information obtained through the phone interviews. We will send these logic models out prior to the site visits to provide the LHJs with a chance to review them, make additions and revisions, and create a more complete version. We'll use the updated versions as an organizing tool for portions of the site visit.

Prior to beginning our discussion with each group at each site, we'll explain the overall purpose of the project, define community health assessment, describe what we want to accomplish through the site visit, and give the participants a chance to ask any clarifying questions they may have. We'll emphasize that we want to learn as much as we can about how each of the six LHJs participating in site visits developed its approach to community health assessment practice so that other LHJs can implement similar methods.

Common Questions/Tasks for Site Visits – LHJ Director and assessment staff discussion

1. Task: Review the revised logic model and identify necessary changes to improve its clarity and completeness.
2. Question: What would you identify as the most critical elements of the logic model – the ones the LHJ couldn't do without and still have an effective community health assessment function, e.g., if you only had two resources to perform two activities to achieve two outcomes, with two external variables affecting you, what would each of them be? Why?

Probe: Thinking back over the evolution of community health assessment in your LHJ, were there other elements that were critical historically (e.g., specific resources or changes at a critical juncture in the development of your assessment capacity)?

3. Question: What are your biggest successes with community health assessment, i.e., those situations where assessment made a critical difference in achieving a particular outcome. Describe one situation internal to the LHJ and one involving the community.
4. Task: Break down the factors that made those successes happen (do internal and external separately). Spend time teasing out the factors and how the LHJ brought them to bear in achieving success. For example, one factor was that two people in the community really wanted to see a needle exchange program in their county – one of them was a former police chief from a large city and carried a lot of weight with the county commissioners. The other was a citizen activist who had been working on a variety of social and health issues for years; reports of children finding used needles in the parks really concerned her. The LHJ created a task force and invited both to participate; they were the group's champions with the commissioners. (Prompt for the role of champions, ability to mobilize funding, DOH/LHJ or inter-LHJ partnerships, role of community advisory groups, particular decision-making structure of LHJ or community/local government entities, changes in attitudes or relationships or other groundwork that facilitated success, etc.).
5. Question: How have you developed the resources (including staff, community participation, BOH interest, etc.) you utilize in performing community health assessment? (Prompt for training or staff skill-building methods, resource leveraging, assistance from DOH, peer learning, etc. that have helped the LHJ to achieve the most it can with its resources.)
6. Question: What have you found to be the most effective strategies for engaging the community? What specific steps have you taken to develop relationships that facilitate community use of health assessment data? How have stakeholder interests affected what you do in assessment? Please provide examples. If stakeholder goals/interests are in conflict with your goals/assessment results, how do you deal with those conflicts?
7. Question: In what ways are your stakeholders/community a resource for your LHJ's assessment capacity (i.e. how do they assist you in conducting assessment activities that lead to changes in awareness, attitudes, knowledge/skills; changes in programs, policies, and resources)? Please provide examples.
8. Question: What have you found to be the most effective strategies for distributing assessment information, both internally and externally? Please describe internal and

external distribution separately. Do you have samples of distribution materials or strategies we could share with other LHJs?

9. Question: What challenges have you faced in implementing community health assessment? Please describe two significant obstacles and how you addressed them. What are the most important lessons you have learned in the process?
10. Question: What else do you need to do to improve the effectiveness of your community health assessment practice (what resources, activities, external variables, impacts)? Do you have specific actions underway to make these changes?
11. Question: Think about your fellow LHJs; what else would you like to share with them to assist them in developing a successful community health assessment practice? What lessons learned can you identify? In hindsight, what would you have done differently that would be instructive to others?
12. Question: What methods would be most effective in helping other LHJs to implement the model approaches you've been using? Think about if you were to add a new capacity to your assessment practice, how would you want to learn it? For example, have a mentor from an LHJ that is proficient in that practice come to your office and teach you how to do it and answer your follow-up questions via emails and phone calls; have an online questions and answers site where DOH staff could respond to LHJ technical data issues, etc.
13. Question: What else would you like to know about how to enhance the effectiveness of assessment in your LHJ?

Common Questions/Tasks for Site Visits – Stakeholder/other LHJ staff focus groups

Note: We will spend additional time at the beginning of these sessions to make sure participants are clear about the definition of community health assessment being used in this process.

1. Task: Identify the ways participants have worked with, been assisted by, or participated in the health department's/district's community health assessment activities. Have each participant describe this for his or her organization (probe especially for resource impacts).

We are looking for model approaches that can be replicated elsewhere in the state. In order to help others, can you tell us what you liked about your experience? What did you dislike? What would you like to see happen?

2. Question: Has the health department/district influenced the way your organization understands or responds to community health issues? Ask the participants to give examples. Probe for changes in awareness, attitudes, and knowledge/skills; changes in policies, programs, and resources.
3. Question: Can you identify specific things the health department/district did that had the most important impact on you/your organization (e.g., particular assessment report, access to data, technical assistance in understanding or using data)?
4. Question: What other changes are you aware of that have resulted from department/district's efforts to understand the health of the community through data and assessment? Probe for changes in awareness, attitudes, and knowledge/skills; changes in policies, programs, and resources. What are the key factors in bringing about these changes?

In what ways have you and your organization influenced how the health department/district uses data? How have you influenced the community assessment process in general?
5. Question: Why is data important to this community for planning ways to improve the community's health? Are there additional examples of how this community has used or could use health assessment data (other than those we've already talked about)?
6. Question: How did you develop your current working relationship with the department/district in regard to assessment activities (e.g., who initiated the relationship, how long has it been in existence, what challenges have you and the health department/district experienced, how have you dealt with these challenges)? Remind participants to focus on community health assessment activities. Probe: What specifically did the department/district do that helped the relationship?
7. Question: What is the most important role the health department/district can play in helping this community identify, understand, and act on local health issues?
8. Question: What could either the health department/district or the Washington State Department of Health do to increase the use of data in local decision-making about community health issues?
9. Question: What advice would you give to other communities about working effectively with their department/district to understand community health issues?

Site-Specific Topic Areas for Site Visits

1. Island LHJ

Key topic areas to explore include:

- The development of the assessment function within two sections:
Community Development and Environmental Health
How did this structure come about? What has been the impact of this particular structure? What changes or outcomes has it effected?
- The roles of the Community Health Advisory Board and the Environmental Health Assessment Team -- How were the two groups created? How do they pursue their advocacy work on behalf of public health issues? What has been their impact?

2. Jefferson LHJ

Key topic areas to explore include:

- Marketing assessment to the community as an investment
- Partnership with Kitsap and Clallam on developing local indicators
- Developing reliable databases
- Working with an assessment coordinator with public health field experience but no background in statistics

3. Kitsap LHJ

Key topic areas to explore include:

- Mapping assessment data/GIS
- BT as a complement to assessment work
- Learning/getting data from other LHJs

4. Kittitas LHJ

Key topic areas to explore include:

- Jane Wright's skill-building over time and her efforts to learn on the job
- Current efforts to develop local health indicators with the help of internal and external partners
- The role of the Board of Health Advisory Committee – How was the group created? How does it pursue its advocacy work on behalf of public health issues? What has been its impact?

5. **Spokane LHJ**

Key topic areas to explore include:

- Local community health indicators
- Collecting/using data from community partners
- Getting support for prioritizing assessment within the LHJ

6. **Thurston LHJ**

Key topic areas to explore include:

- Dealing with data requests – how to manage the volume and help stakeholders refine their requests.
- Getting long-term staff to value assessment
- The role of the Community Health Task Force – How was the group created? How does it pursue its advocacy work on behalf of public health issues? What has been its impact?

Site Visit Protocol

Prior to the Site Visit

Task	Details
Contact selected site	<ul style="list-style-type: none">▪ Confirm primary contact person▪ Choose site visit date▪ Discuss potential interviews and focus group participants and documents/materials available for review▪ Identify other logistics or site-specific issues of importance▪ Identify next steps and responsibilities
Pull together site information	<ul style="list-style-type: none">▪ Create logic model for site based on telephone interview responses. Identify missing information, unique features, or issues for targeted questions. Send logic model to primary contact and request revisions prior to the site visit.▪ Request organizational chart for LHJ▪ Collect LHJ demographic and other descriptive information▪ Review LHJ websites for assessment information
Customize site visit interview questionnaire(s) and focus group guide(s)	<ul style="list-style-type: none">▪ Add questions related to missing information (or identify documents that will be available for review to provide needed data)▪ Add questions related to unique site features/issues

Finalize site visit plan	<ul style="list-style-type: none"> ▪ Confirm site visit schedule, including group discussion, focus group, and interview participants ▪ Confirm document/materials available for review ▪ Get any directions, maps, or instructions needed
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During the Site Visit

Task	Details
Facilitate staff discussion	<ul style="list-style-type: none"> ▪ 2 hour meeting ▪ Participants should include LHJ Director and all assessment staff
Facilitate focus group with stakeholders and BOH members	<ul style="list-style-type: none"> ▪ 1.5 hour meeting ▪ Participants should include key external (non-LHJ staff) assessment stakeholders (e.g., BOH, task force or advisory committee members) ▪ Optimal number of participants = 6 to 8 stakeholders
Facilitate focus group with other LHJ staff	<ul style="list-style-type: none"> ▪ 1.5 hour meeting ▪ Participants should include key LHJ assessment stakeholders (e.g., management team, program staff) ▪ Optimal number of participants = 6 to 8 staff
Individual interviews	<ul style="list-style-type: none"> ▪ 2 hours ▪ Up to 4 one-hour follow-up interviews with primary contact person, staff working on assessments, and/or key stakeholders not available for the focus groups (there will be two Clegg & Associates staff, so two interviews can run concurrently)

After the Site Visit

Task	Details
Prepare summary	<ul style="list-style-type: none"> ▪ Identify findings, key themes, strategies, and other information from the interviews, focus groups, and observations ▪ Identify key findings and information from the record review
Call LHJ contact person	<ul style="list-style-type: none"> ▪ Get additional information related to missing data or unanswered questions from the site, if needed
Send thank you	<ul style="list-style-type: none"> ▪ LHJ Director and contact person ▪ Interviewees and focus group attendees ▪ Others as needed

Literature Review Sources

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<http://www.servicefirst.gov.uk/2000/guidance/bpresearch.htm>.

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Prepared for the Assessment In Action Steering Committee

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